S. HRG. 101-975

DEFINING THE FRONTIER: A POLICY CHALLENGE

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

CASPER, WYOMING

JULY 23, 1990

Serial No. 101-25

Printed for the use of the Special Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE

34-175 WASHINGTON : 1990

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

S141-2.

SPECIAL COMMITTEE ON AGING

DAVID PRYOR, Arkansas, *Chairman*

JOHN GLENN, Ohio	JOHN HEINZ, Pennsylvania
BILL BRADLEY, New Jersey	WILLIAM S. COHEN, Maine
QUENTIN N. BURDICK, North Dakota	LARRY PRESSLER, South Dakota
J. BENNETT JOHNSTON, Louisiana	CHARLES E. GRASSLEY, Iowa
JOHN B. BREAUX, Louisiana	PETE WILSON, California
RICHARD SHELBY, Alabama	PETE V. DOMENICI, New Mexico
HARRY REID, Nevada	ALAN K. SIMPSON, Wyoming
BOB GRAHAM, Florida	JOHN WARNER, Virginia
HERBERT KOHL, Wisconsin	NANCY LANDON KASSEBAUM, Kansas

PORTIA PORTER MITTELMAN, *Staff Director*
CHRISTOPHER C. JENNINGS, *Deputy Staff Director*
JEFFREY R. LEWIS, *Minority Staff Director*

CONTENTS

	Page
Opening statement of Senator Alan K. Simpson	1
Mary Netzner, home health care consultant, Wyoming Department of Health and Social Services	8
Ken Heinlein, interim administrator, Wyoming Department of Health and Social Services	10
Carol Miller, MPH, Chair, Rural Health Committee, American Public Health Association, assistant director, La Clinica Del Pueblo, Tierra Amarilla, NM	13
Dr. Larry Meuli, M.D., administrator of health and medical services, State of Wyoming	27
Evonne Ulmer, administrator, Weston County Hospital, Newcastle, WY, chairman, Wyoming Hospital Association	37
Dr. David Driggers, M.D., director of the Netrona County Family Practice, program director, University of Wyoming Family Practice Residency Program	50
Steve Zimmerman, Administrator of the Division of Community Programs, Wyoming Health and Human Services Department	63
E. Scott Sessions, director, Wyoming Commission on Aging	70

APPENDIX

Item 1. Additional testimony and recommendations, with attachments, submitted by Carol Miller, MPH, Chair, rural health committee, American Public Health Association, assistant director, La Clinica Del Pueblo, Tierra Amarilla, NM	93
Item 2. Article from health services research entitled "A Research Agenda for Rural Health Services," by Alice S. Hersh and Robert T. Van Hook	188
Item 3. Testimony from Home Oxygen Plus Equipment, a supplier of oxygen and related equipment, detailing difficulties and remoteness of delivering services	194
Item 4. Testimony, with attachments, from the Cody Council on Aging, submitted by Rose Miller, Director	211
Item 5. Testimony from the Wyoming Medical Society, submitted by Richard W. Johnson, Jr., executive director	215
Item 6. Testimony from the Glenrock Senior Citizens, Inc., submitted by Evalyn Hoover, project director	217
Item 7. Testimony, with attachments, from the Wyoming State Hospital, submitted by Mary Kramer, nursing facility placement coordinator and Leon Clyde Pruett, superintendent, RE: Individuals affected by OBRA PASARR Reviews	220
Item 8. Article from the Star Tribune entitled "Doctors Doubt Medicare Help Coming from Feds," by Will Robinson	228
Item 9. Medicare form, submitted by Verda Billings, showing gap between what Medicare pays and what doctor charges	230

DEFINING THE FRONTIER: A POLICY CHALLENGE

MONDAY, JULY 23, 1990

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Casper, WY.

The committee met, pursuant to notice, at 9:35 a.m., in the Ballroom at Casper College, 125 College Drive, Casper, WY, Hon. Alan K. Simpson presiding.

Present: Senator Simpson.

OPENING STATEMENT BY SENATOR ALAN K. SIMPSON

Senator SIMPSON. This meeting of the Special Committee on Aging of the U.S. Senate will come to order.

On behalf of the other members of the Special Committee on Aging who are not here I do thank you for coming. Jay Rockefeller said "It was nice of you to invite me, Al, but I'm not coming." Dave Pryor, who is our Chairman, a very splendid man from Arkansas and one of the few U.S. Senators who is not opposed in either his primary or general election—he is a Democrat who came to the Senate when I did—has been very dear to allow these field hearings to occur.

They usually do occur without any other Senators from any other areas appearing. What we are trying to do is determine the uniqueness of each State. The Federal Government just makes no distinction between "frontier" and "rural," and they can't understand our delivery systems in other parts of the country.

So when we get all this compiled, each Senator on the Aging Committee will have held similar types of hearings in their own States, to demonstrate whether the systems we have in place now are working, and are appropriate to all parts of the country.

That is the purpose of this hearing: to get at a definition of the word "frontier" and you will hear that word, and to differentiate that from "rural" and of course, "urban." For example we have counties in Wyoming where the principal community comprises 70 percent or 80 percent of the county's population base. Then we have this dispersion which is much less than six persons per square mile. These areas are treated by the bureaucracy almost as if there is no one there. We want to show that there are people there.

On behalf of the Senate Special Committee, I thank you. It is a privilege to be here. Ann happens to be with me this morning. We have to be back in Washington tonight. We were here for the Presi-

dent's visit and activities of a political nature in Buffalo and Casper.

We also have a number of people who have traveled a very long way, and I appreciate that, and we want to hear their concerns. They have written testimony which will be accepted into the record. So their time may be somewhat limited here, but I think concern and involvement like this makes the process work. It does work. It is often very sloppy and very frustrating, but that is called democracy. I want to thank the witnesses for their help and participation. I want to thank Leslie Tucker, who has been a very able staff person, who I hired simply for her expertise on health care issues. Let me tell you, they are complex. She has done a very fine job with this, and worked diligently.

As I say, we hope to make a contribution to Congress' understanding of what it means to work and live and deliver services in the Nation's "frontier" areas. We are on a kind of a mission of sorts here today. We are going to begin the process of educating Congress and the Federal Government about what life is really like out here in the Rocky Mountain Region, and what is like to live here in Wyoming if you need health or social services, or if you are trying to provide them. We are doing that with an eye toward making Congressional policies and Federal regulations more responsive to the special needs and circumstances of a profoundly rural State.

We hear people talking about the program payment differentials between urban and rural areas, and we made some strides to correct that in November. They were small strides, but they were visible. We see this tremendous loss of physicians to more sophisticated and profitable urban settings. We see a shrinking pool of allied health and community service professionals in virtually every field. The population of rural America is growing older and more frail, requiring more and higher levels of service. Health care and supportive services are in great demand, and our challenge is to try to craft public policy response that is appropriate to all regions.

As I say, you are going to read a lot, and have already read a lot, about the term "rural," a subject of a record number of speeches and press releases and hearings and legislation. Unfortunately, all that activity will be of only marginal benefit to Wyoming unless the implementing policies are crafted with the understanding that the rural areas of the United States are not alike. Rural Iowa is not like rural Wyoming. Yet they are both described under the ruberic of "rural."

Rural America is very complex, and very diverse. I want to pay tribute, and then we will go on, to those who labor under this kind of situation. What they do is, they don't get a large share of the money, but they are very dedicated and creative people who squeeze the most out of it. Wyoming's program people are deeply committed to providing the kind and quality of services their clients need. Sometimes they have to bend convention to do that, and they do. I am proud to say that they do that in a creative, not manipulative, not in an illegal way, but in one word, they are crafty as hell.

You are going to hear some of that, then the Government won't feel uncomfortable about what we do. We are going to look at this

new word "frontier," and examine those things, and see that things are not done to frustrate the issues, and you can help us, as instructors and advocates for those who live and practice with real dedication.

I will ask that the balance of my remarks be included in the record as if read in full.

[The prepared statement of Senator Simpson follows:]

Opening Remarks

SENATOR ALAN K. SIMPSON

"Defining the Frontier: A Policy Challenge"

A field hearing by the

U.S. Senate Special Committee on Aging

July 23, 2990

Casper, Wyoming

Call to order.

Good Morning, ladies and gentlemen. On behalf of the United States Sentate special Committee on Aging, I would like to thank you all for coming today. I understand that we have a number of people in the audience who have travelled a long way to be here today -- I appreciate that. It is concern and involvement and participation like that that make this process work.

I also want to thank our witnesses for their help and participation -- you will make an important contribution to Congress's understanding of what it means to live and work and deliver services in the nation's frontier areas.

Ladies and gentlemen, we are on a mission, of sorts, here today. We are going to begin the process of educating Congress and the federal government about what life is really like out here in the Rocky Mountain region -- about what it's like to live here in Wyoming if you need health or social services or if you are trying to provide them. We are doing this with an eye toward making Congressional policies and federal regulations more responsive to the special needs and circumstances of our profoundly rural state.

Rural health care is experiencing a renaissance of interest in Congress. The last few years have witnessed an alarming number of hospital closures in rural areas, the loss of physicians to more sophisticated and profitable urban settings, and a shrinking pool of allied health and community service professionals in virtually every field. At the same time, the popuation of rural America is growing older and more frail -- requiring more and higher levels of service. Clearly, Congress has reason to be seriously concerned about issues of access to health and supportive services in rural regions. Our

challenge will be to craft a public policy response that is appropriate to All rural regions, including -- and especially, from this cat's seat! -- Wyoming.

That will be hard to do without some refinements in the way my colleagues in Congress -- the vast majority of them from the urbanized Eastern and Western Seaboards -- think about the term "rural". During the last Congress, rural health care was the subject of a record number of speeches, press releases, hearings and legislation that was introduced and enacted into law. Unfortunatley, all of that activity will be of only marginal benefit to Wyoming unless implementing policies are crafted with the understanding that not all rural areas are alike.

Rural America is complex and diverse. Although similar in population, Vermont and Wyoming are vastly different in terms of heritage, resources, and economic base. Not to mention that fact that the entire state of Vermont could fit into two of Wyoming's southwestern counties. Or take Iowa -- with its its many urban centers and little towns sprinkled every 10 or 20 miles in between -- which Washington, D.C. considers to be the very epitome of a "rural" state. Wyoming clearly does not fit that model: our major towns are twice as far apart and we have virtually nothing in between! Yet my colleagues in Washington seem to believe that if a program or a rule or a regulation will work in Iowa, then it will work anywhere "rural", including Wyoming. Isn't that something?

Up until very recently, program providers, administrators, and beneficiaries could still make a ready go of it even under federal laws that were designed to fit counties and regions east of the Mississippi. Federal assistance for many programs came to the states in the form of flexible block grants with only broad and general guidelines attached. States were given instructions to serve this or that population or provide this or that service, and then were left to do that in whatever fashion best fit their particular mix of people and circumstaces. Because of her small population, Wyoming never got a very large share of that money, but she has always had some very dedicated and creative people to squeeze the most mileage out of it. Wyoming's program people are deeply committed to providing the kind and quality of services their clients need. And sometimes they'll bend conventions a little to do it. That is, they are crafty as hell! I am proud to say that.

But more and more, the federal government -- and some of my colleagues in Congress -- seem uncomfortable when the folks "out there" in the trenches take too much initiative with federally-assisted programs. The pendulum is swinging in the other direction now; flexibility is being replaced by a "Washington knows best" approach to health and human service grants. Rules and requirements are heaped on to make sure the local people "do it right". Not only do they sap the vitality and creativity and resourcefullness out of the programs, they may drain funds from other areas that the local folks have identified as more pressing priorities. In a place like Wyoming, with so few resources at its own disposal and so many urgent needs, that can be devastating.

-- Example: A new federal law requires each state to allocate almost half of its substance abuse treatment grant to treatment for IV drug users. If that state fails to meet this requirment, it loses the entire grant. Wyoming does not have an IV problem of any great proportion, but it must set-aside these funds. Meanwhile, victims of alcoholism wait 6-8 weeks between visits to the treatment center -- which is funded by the other monies in that same grant -- because there is not enough money to pay for another counselor.

Even more confounding than their effect on local resource allocation are the consequences of federal program rules on service delivery in remote rural regions. Almost without exception, federal health and socal service programs are becoming every more unresponsive to the special needs and circumstances of remote rural or "frontier" areas. Federal payment policies and program rules, for example, while becoming ever more detailed and prescriptive, do not recognize the distances that patients and providers must travel, over sometimes impassable roads, for services; or the different ethnic mix of remote regions; or the combined effect of essential high-cost, low volume services on remote facilities.

This may be in part owing to the fact that we do not have a standard definition or set of criteria to describe what and where the most isolated rural areas are. In fact, there is no standardization at all in the way rural areas are defined. The Census Bureau defines areas as either urban, urbanized, or rural. The Office of Management and Budget defines areas as Metropolitan Statistical Areas or Non-Metropolitan Statistical Areas. Agencies within the federal government may use one or the other or both of these definitions for

their various programs. Yet none captures the nature of isolated rural or "frontier" areas.

It is indeed difficult to quantify rural health care problems and to make informed policy decisions without a clear definition of what and where these are. We intuitively associate the word "rural" with small population, sparse settlement, and remoteness. But these features exist on a continuum -- with Iowa perhaps at one end and Wyoming at the other. Dichotomous definitions such as the government uses fail to capture that.

Other sectors -- most notably those involved in economic development -- define "Frontier" areas as those with fewer than 6 people per square mile. Under that definition, 19 of Wyoming's counties qualify as frontier regions.

It is time that we introduce a new word, "frontier", into the official health and human services lexicon of Washington, D.C. As I mentioned earlier, Washington has of late come to take seriously the differences between urban and rural areas -- at least as Washington perceives "rural". We need to push that new understanding one step further, to an awareness of the very unique needs of isolated rural or "frotier" areas. These regions are as different from rural areas as rural areas are from urban ones, and their needs and resources are distinct.

This hearing of the Senate Special Committee on Aging will examine some of those special needs as well as some of the uniques circumstances that characterize frontier areas. We will hear testimony from state program administrators and providers who daily must match means to ends under program regualtions that seem expressely designed to frustrate their very purposes -- that is, to get services to people -- because they were not written with frontier regions in mind. We will also hear from some experts who have done a great amount of work on behalf of the Nation's "frontier" regions, as instructors and advocates for those who live and practice with such dedication in these isolatied areas.

Senator SIMPSON. The first panel will consist of Mary Netzner, who is a home health care consultant in the Department of Health and Social Services. She oversees a number of the State's public health nurses, and helps negotiate problem cases, a number of which are the products of Federal laws. Home health care personnel provide health care and assistance to the frailest members of the community, people who could not survive outside an institution without regular, attentive care. It's quite a job.

It's very good to have you here, Ms. Netzner. You will be leading off.

Then the second member of the panel is Ken Heinlein. Ken is the Interim Administrator for the Department of Health and Social Services. It is his job to assure that programs offered by the State are available to all who need them, and that they all comply, down to the last of the rules, regulations, and mandates handed down by Washington. It is a pleasure to have him here with the facts and figures to set the context of the hearing.

Then we have Carol Miller, who has been very good to come such a long way from New Mexico for this. She has worked as an analyst in the Department of Health and Human Services in Washington and is a public health officer in New Mexico. She is a long-time advocate on behalf of rural health care, and is now chairman of the Rural Health Committee of the American Public Health Association. She is also indeed an expert—and I mean that—she is an expert in the issues we are discussing today. She made a special effort to come here.

Mary, if you will proceed with your remarks within the time constraint and then we will go to Mr. Heinlein and Carol Miller, and I will ask questions after the three of you have completed your remarks.

Thank you very much.

STATEMENT OF MARY NETZNER, HOME HEALTH CARE CONSULTANT, DEPARTMENT OF HEALTH AND SOCIAL SERVICES

Ms. NETZNER. Thank you, Senator Simpson.

When I was in graduate school in Denver, they kept talking about rural issues. Every time they talked about rural issues, they looked at me. I'm from Cheyenne, I have lived and worked in Cheyenne. I kept looking around to see who they were talking to that was sitting by me.

Finally, I said "Are you looking at me when you say rural?" They said "Yes." I said "I'm from Cheyenne." They all laughed.

Then they explained what the definition of "rural" was. Then I wondered—if Cheyenne is rural, if Casper is rural, what are Lusk and Morecroft and Afton? It was after graduate school that I heard the definition of "frontier." That made sense.

We had a lot of issues in public health and home health out in the outlying areas that we don't have in Cheyenne and Casper. I am here to tell you some of our war stories.

We had a situation in Lincoln County where we had a man coming home from the hospital after having a CVA-stroke. He was completely paralyzed on the left side. He came home one evening,

and a nurse went out to the ranch the next morning to start services. We thought physical therapy and nursing and some aide services would be appropriate.

When she got out there about 10 o'clock in the morning and was taking the history and assessment, she found out that the man had driven into Kemmerer the afternoon before. She asked him how he had driven with his left side completely paralyzed. He said when he got home, he realized that unless they drove that pickup, they were stranded. There wasn't anybody around for miles and miles.

So he thought it over, and he got a couple of his leather belts, and put them together, climbed into his pickup, which was a feat in itself, and got it into first gear, got it out on the road, slipped the belt around his left foot and when he was ready to change gears he just reached over with his right hand, pulled his foot up with the belt, dropped it on the clutch, put it in second, and went on down the road.

Right away that precludes him from meeting the home-bound criteria for Medicare. All those services were not available to him. We provided services some other ways, but we were not able to get any Medicare benefits for him.

Another situation we had was a woman in Lovell who needed I.V. therapy. We have one nurse that covers the northern end of Big Horn County. The patient needed the I.V. therapy three times a day. One nurse covering that area could not do it three times a day. The way we set it up was that the school nurse, who had I.V. skills, drove past the house on the way to school in the morning. She went in and provided the morning therapy then the public health nurse went in and did the afternoon therapy. The physician lived right behind her, so he went in at 10:00 o'clock at night, before he went to bed, and did the third dose.

Again, this did not meet the standards for home health services, but we did get the services delivered.

Another story that I have, the outcome is not as good. We had a woman who was living on a ranch outside of Kay Cee, 15 miles out of town, in Johnson County. She lived 5 miles off improved road. She was dying of a cerebral abscess. The only services we really had available was a visit by a nurse once a week. That's because she lived so far outside of where the home health agency could provide services that it really was not cost effective. They did not have the people out there, and did not have people to send out there. So she did not get very much in the way of services.

The senior center put up meals for the family, and the public health nurses, when they went out, took about 14 frozen dinners all wrapped up, so that she would have some meals during the week.

Another situation that we are running into now is that some of the standards for home health agencies are a little hard to enforce or to live with in our communities. The situation that the Medicare surveyors are walking around is that a nurse is supposed to be available by phone, at least, when an aide is in the home.

We have situations where we will have one nurse to cover the county or an area of the county, and she could be on her way to a patient's home, and the patient does not have a telephone, we do not have telephones in the car, and the aide may be in a home

where there is not a telephone. There is no way that the aide can be in telephone contact with the nurse. Because of the distances, the nurse may be without a telephone for half a day.

When we were trying to write policies to cover this, and keep us within this standard, the head of the survey team suggested we carry a beeper. If you have a beeper, that's fine, you still have to get someplace where there is a telephone. They are not enforcing that standard yet. But if they did, it would mean about a third of our agencies would have to decertify, which would mean there would not be Medicare home health services from those agencies.

Senator SIMPSON. Thank you very much.

Mr. Heinlein.

STATEMENT OF KEN HEINLEIN, INTERIM ADMINISTRATOR, DEPARTMENT OF HEALTH AND SOCIAL SERVICES

Mr. HEINLEIN. Thank you, Senator Simpson.

Wyoming is a large and largely rural State, with an average population density of less than five per square mile. Twenty percent of the population lives in either Cheyenne or Casper. Ignoring these two major cities, the remainder of the State has a population density of less than four per square mile.

The context of these numbers will be reflected or have been partially reflected in what Mary has said, and what will be said by some of the other speakers. Bear with me while I give you a few more numbers to give you more context for moving ahead.

Wyoming has 101 incorporated cities, towns or census designated places, or about 980—let's say 1,000—square miles per place. Of these 101 places, the 56 smallest, if all brought together would not even make a crowd at RFK or Mile High Stadium, or even fill a fifth of the Rose Bowl in Pasadena, CA. These 56 places combined have a population of less than 20,000 people.

In addition, 29 percent of the population is in unincorporated areas not including any of these 101. Wyoming has 27 acute care hospitals, which is the same as the State of Delaware. If you will look at the map there, the red dots represent the acute care hospitals in the State, and the distribution of them. That makes one hospital for every 3,600 square miles on average. The State of Delaware has 1,933 square miles. We have about one hospital for every 18,000 people, on average.

The population per hospital is why so many of them are financially marginal. The area covered is why they are so medically necessary.

What difference do these statistics make? Here are two examples. Every time a law is passed in Washington, or a regulation written affecting hospitals, Wyoming has to apply that regulation from the equivalent of Washington, DC to Columbus, OH, from Washington DC to Port Huron, Ontario, from Washington, DC to Buffalo, NY, and nearly as far north as Syracuse, NY.

When Congress establishes a service targeted to a low-prevalence population, say 1 in 1,000, Wyoming must search from the equivalent of Washington, DC to Columbus, Port Huron, and Buffalo, for the 500 people within that geographic area that we must serve with those dollars.

The more specific the restrictions, the more difficult the search. Wyoming's communities and service providers are highly committed to quality for its services, but it is essential that we have as much flexibility in delivering these services as we possibly can.

Let me, if I may, show you this map. Take Cheyenne and put it over Washington, DC. That's what we have to cover for our services. The relevance of Delaware—Delaware might not make a normal comparison to Wyoming, except that they also have 27 acute care hospitals. I will put Delaware up here, so you can see the comparison. That's Delaware, with 27 acute care hospitals, and Wyoming's 27 acute care hospitals.

[The prepared statement of Mr. Heinlein follows:]

Ken Heinlein's Comments to the Senate's Special Committee on Aging.

Senator Simpson, Members of the committee

Welcome to Wyoming, I hope that you can stay long enough to experience the uniquely rural aspects of the state, and thank you for the opportunity to appear before your committee.

Mindful of the time limitation, let me get straight to the point.

My colleagues and co-workers will discuss specific issues of concern, I would like to provide an overview of the state that will help set the stage for their remarks.

Wyoming is a large, and largely rural state. It has a average population density of less than 5 per square mile, with 20% of the population in either Cheyenne or Casper, each having about 50 thousand people. Ignoring these two major cities, the remainder of the state has a density of less than 4 persons per square mile.

Wyoming has 101 incorporated cities and towns, or Census Designated Places, **or about 980 (say 1000) square miles per place.**

- Of these 101 places, the 56 smallest, if all brought together would not even make a crowd at RFk Stadium, nor fill even a fifth of the Rose Bowl stadium. These 56 places combined have less than 20,000 people.
- In addition, 29 per cent of the population is in unincorporated areas, not included in the 101 places.

Wyoming has 27 acute care hospitals (which is the same as the state of Delaware), or one hospital for every 3,600 square miles (Delaware has 1,933 square miles) **or one hospital for every 18,000 people.** The population per hospital is why so many of them are fiscally marginal, the area covered is why they are medically essential.

WHAT DIFFERENCE DOES THIS MAKE?

Every time a law is passed or regulation written affecting hospitals, Wyoming has to apply that law or regulation from the equivalent of Washington D.C. to Columbus, Ohio; to Port Huron, Ontario; to Buffalo, New York, and nearly as far north as Syracuse.

AND

When Congress establishes a service, targeted to a low prevalence populations, say 1 in a thousand, Wyoming must search from D.C. to Columbus, Port Huron, and Buffalo to find the **500, within that geographic area** to whom the target applies. The more specific the restrictions, the more difficult the search.

Wyoming is highly committed to quality standards for its services, but it is essential the we have as much flexibility to meet service priorities as is possible.

Senator SIMPSON. It's very dramatic presented in that fashion. I appreciate that very much.

Now, Carol Miller, please.

STATEMENT OF CAROL MILLER, MPH, CHAIR, RURAL HEALTH COMMITTEE, AMERICAN PUBLIC HEALTH ASSOCIATION, ASSISTANT DIRECTOR, LA CLINICA DEL PUEBLO, TIERRA AMARILLA, NM

Ms. MILLER. Thank you, Senator Simpson. I appreciate the opportunity to address this very important field hearing of the Senate Special Committee on Aging.

It is a pleasure to be in Wyoming to discuss the health and social service needs of frontier areas.

Today is almost 21 years to the day when I first came to Wyoming. I have to say that I came to Wyoming an Easterner and I left 3 weeks later a confirmed Westerner. I have not left the Rocky Mountain States since. If I had never come to Wyoming, I don't think I would be the person here to talk about frontier health and social service programs.

My testimony is a little longer than the others. I am going to set the framework for where the frontier concept came from, and where we hope it is going. Recognition of frontier needs and the development of programs and regulations that will work in frontier areas is very necessary. It will help our country eliminate a pervasive form of discrimination—geographic discrimination—where the more populated areas and their representatives develop programs that are inappropriate for sparsely populated large geographic areas. It is fitting that this discussion take place in Wyoming, the Equality State, where the State motto is "Equal Rights."

Why are frontier areas important? Activists for appropriate health and social service programs in frontier areas, like myself, are always being told that our concerns are irrelevant, that no one lives there, and that urban needs are more important. We cannot allow that urban attitude to either ignore or discriminate against 45 percent of our country.

If you look at the map,[1] the areas that are blacked out on that large map are counties with six or fewer persons per square mile, which is one of the proposed definitions of frontier. We are talking about a tremendous part of the country. Using that definition there are 27 States with frontier areas.

Frontier areas are extremely important to the wealth of the United States. These areas contain natural resources like timber, water, wildlife, grazing lands, minerals, oil, gas, most of our national parks and forests, Indian reservations, our richest farmland at the eastern edge of the frontier, open space, and military installations essential to our national security. There are no east-west transportation or communication systems that do not cross extensive amounts of frontier land.

Millions of people pass through frontier areas every day from other parts of the United States. Those who get sick or have an ac-

[1] See p. 104.

cident expect that someone will be there to help. And there are people there, most often the volunteer Emergency Medical Technicians that arrive with an ambulance, or there is a small clinic or health facility, usually with underpaid and overworked health care providers who are struggling to keep their practices going in a system that is working against them.

I am a volunteer Emergency Medical Technician in New Mexico. It is extremely difficult to cover the large areas that we do. One thing that is unique about frontier areas is the sense of volunteerism and people helping people that we just take for granted that I don't think happens in other places.

Just to give a brief history of the Frontier Health Movement, in 1893, just after the 1890 Census, people on the East Coast decided that there was no longer a frontier in this country. They had thought there was up until that point, and I don't know whether it was Wyoming joining the Union that convinced them that there was no frontier left, but it was the 1890 Census from which they determined that the frontier had been conquered. They were using a definition of two or under per square mile.

However, in 1984, the frontier was reborn. Frank Popper, who has been the guiding light of this return to the frontier, is a demographer, interestingly enough, in urban studies in New Jersey. He looked at the map again and said "Wait a minute. We still have a frontier." It's no longer a line, although it is pretty close to a line, if you look at a map like this. There are frontier communities and places all over the country.

In 1980, one-quarter of the United States had a population density of less than two per square mile. Even in California, which has 4 of the 16 largest cities in the United States, 7 percent of the land area is frontier counties.

"For a place that was supposed to have disappeared generations ago, a lot of frontier is still left. The frontier is off the beaten track, our national governing classes, as well as many of the rest of us, have no reason to notice it. At best, it is a place to fly over." That was the opinion of Dr. Popper, the demographer.

However, those of us who live in frontier areas—well, there are some things we do not want people to notice about us, so they don't all want to move in. But there are other things we hope they do notice. Our tasks of providing services in these areas are very difficult.

In 1985, the Public Health Service called together a group of people to establish a Frontier Health Care Task Force. This group worked very hard coming up with some definitions of frontier. We were successful in getting one of the bureaus of the Department of Health and Human Services, the Bureau of Health Care Delivery and Assistance, to adopt a definition of frontier and supposedly give special consideration to frontier areas.

The U.S. Senate, led by Senator Hatch of Utah, did get special consideration of frontier areas into two pieces of legislation. But some of us working in the frontier think that is too hit or miss.

Then you have the problem we are talking about, where one program is administered one way, and another program is administered differently. The Frontier Task Force, now a part of the National Rural Health Association, decided last November to start ad-

dressing various forums like this, and talking to people in Congress about a uniform definition of frontier. For example, an amendment to the preamble of the Public Health Service Act so that all programs under that act would take into account the special considerations of frontier areas.

It has been very hard to establish this definition, and I am going to lay out a few guidelines this morning. The Office of Technology Assessment was asked by Congress to define rural, and tell them what a rural area is. I see others have copies of that report here. What they did was come up with a 70-page report that said rural is a lot of things to a lot of people, and there are a lot of definitions, and we are not going to risk making one.

They basically said—and this is the jam that people who work in programs, I am sure, get into all the time—the Census Bureau defines it one way, the Department of Agriculture defines it another way, Health and Human Services defines it at least four different ways that I know about, whether it is the Health Care Financing Administration, defining a rural hospital, the National Health Service Corps defining a rural area, of other programs.

The Office of Management and Budget also has their own definition. However, it is very important to come up with a standard definition of frontier, because not having one is too divisive. Recent legislation in 1988, Section 799(a) of the Public Health Service Act, Interdisciplinary Training for Rural Areas, has now defined frontier as seven or fewer per square mile.

We think one thing that has happened is that people are hooked on a number. Now there is a big debate as to whether it is six, seven, what is it? I would like to propose today, and hopefully the Senator will take this back to Congress, that there are a combination of characteristics that make up a frontier area. It is not solely a magic number of how many people live in the county.

One thing that there has to be is what we call a service area, or a catchment area. The most reasonable place to set up services is around a trade area. I am sure from the map of the Wyoming hospitals, which are distributed fairly well throughout the State, that they are located in service areas where people are used to going for shopping or other services, in addition to health care.

The other thing is that we have to look at sub-county units. The Senator addressed that. When you have one large population center in a western county, there may be small communities 100 or more miles away, who are not qualified for any kind of Federal assistance. When this assistance is based on a population-to-physician ratio, for example, that one population center will throw the entire county out of eligibility for program support.

In New Mexico, we looked at sub-counties and found that 72 percent of the State was frontier. On a whole county basis, it would be 50 percent. I am sure in Wyoming we could get up to 100 percent of the State that would qualify as frontier.

Another of the important characteristics is distance. The Federal guidelines we have right now, talk about distance to next level of care.

It is not enough to say that here is a small physician's office in a small town in Wyoming and the next level of care is a local hospital that might not be fully staffed. The next level of care has to be

able to handle the 24-hours emergency. In New Mexico, we only have one major trauma center in the whole State of New Mexico. I am sure that's the case here, also. You are feeding people in from other communities and other hospitals. Even your "urban" hospitals are serving primarily the frontier population.

We think it is very important to have States involved in the designation process. Who knows better than local government and Governors what is going on in their State. There are Federal programs that allow Governors and local officials to appeal a designation process and speak for the medically underserved area. I know Wyoming has tried to get designated a number of times, and not qualified, there is a way that the Governor can request a designation.

One point that would be really helpful is that once an area is designated as a frontier, it is going to be frontier for all programs. So if you are a hospital located in a frontier area, you are a frontier hospital. You would not go through the debate as to whether it is rural or frontier. We are going to designate areas, not populations.

I want to read from the policy that the Bureau of Health Care and Delivery Assistance has. We went through months and months of discussion about how to write it. We had to put in there a statement big enough to drive a truck through, which says "Because of the unique nature of frontier areas and the difficulty in developing eligibility criteria which fit all cases, there will be an opportunity for organizations to justify any unusual circumstances which may qualify them as frontier. For example, geography, exceptional economic conditions, or special health needs."

We had to have that in there, because even frontier areas can be quite different from each other.

I am going to run through a couple of specific frontier recommendations I would like to see. One would be a National Center and Clearinghouse for Frontier Health and Social Services. There is now a National Rural Health Information Center jointly operated by the Department of Agriculture and the Department of Health and Human Services. Yet I can't get any information about home health programs in frontier areas, as we heard this morning. I can't get information about how the emergency medical services are different in frontier areas. I really believe we need one national focal point, where we can network and exchange the kinds of information we need. Programs for the elderly, you name it—frontier is totally different from rural.

We need frontier demonstration programs, and I just want to throw out the concept of payments of lieu of taxes, or PILTS. If we were to overlay a map of Federal lands over this map of frontier, there is a tremendous amount of Federal land in frontier areas that does not add to our local tax base. The PILTS primarily go to education and roads.

I would like to see Congress designate some way that we can look at PILTS going into the health and social service system. We do not have the tax base to operate the programs, partly because of this Federal lands issue.

I have other recommendations on other programs, in the written testimony.

I will say one thing about the Medicare Program, because this is the Committee on Aging. I was very happy to hear that Medicare is going to look at more preventive services for the elderly. We find at the clinic where I work that it is very discouraging to tell people that preventive services are not covered under Medicare. It causes real hardship, and people are going without. I think we have learned in health care that preventive services save a lot of money down the road. I hope that the message I heard yesterday does go through as legislation.

Thank you.

[The prepared statement of Ms. Miller follows:]

UNITED STATES SENATE
SPECIAL COMMITTEE ON AGING

FIELD HEARING
CASPER, WYOMING

JULY 23, 1990

TESTIMONY

HEALTH AND SOCIAL SERVICES:
ORGANIZATION AND DELIVERY IN FRONTIER AREAS

CAROL MILLER, MPH
CHAIR, RURAL HEALTH COMMITTEE, AMERICAN PUBLIC HEALTH ASSOCIATION
ASSISTANT DIRECTOR, LA CLINICA DEL PUEBLO,
TIERRA AMARILLA, NEW MEXICO

Senator Simpson: Thank you for the opportunity to address this very important field hearing of the Senate Special Committee on Aging. It is a pleasure to be in Wyoming to discuss the health and social service needs of frontier areas.

Today is almost twenty-one years to the day of my first visit to Wyoming. Since then I have returned to this beautiful state many times. I came here 21 years ago an Easterner and left the state several weeks later a Westerner. I have stayed in the West ever since. In fact, if I had never come to Wyoming, I doubt I would be the person here today talking about frontier health and social service programs.

Recognition of frontier needs and the development of programs and regulations that will work in frontier areas is very necessary. It will help our country eliminate a pervasive form of discrimination - geographic discrimination - where the more populated areas and their representatives develop programs that are inappropriate for sparsely populated, large geographic areas. It is fitting that this discussion take place in Wyoming, the Equality State, where the state motto is "Equal Rights."

WHY ARE FRONTIER AREAS IMPORTANT?
Activists for appropriate health and social service programs in frontier areas are always being told that our concerns are "irrelevant," "no one lives there," and that "urban needs are more important." We can not allow that urban attitude to either ignore or discriminate against 45% of our country.

Frontier areas are extremely important to the wealth of the United States. These areas contain natural resources like timber, water, wildlife, grazing land, minerals, oil, gas, most of our national parks and forests, Indian reservations, our richest farmland at the eastern edge of the frontier, open space essential for re-creation, and military installations essential to our national security. There are no east-west transportation or communications systems that do not cross extensive amounts of frontier land.

Millions of people pass through frontier areas every day from other parts of the US. Those that get sick or have an accident expect that someone will be there to help. And there are people there, most often the volunteer Emergency Medical Techicians that come with an ambulance or other dedicated (usually under-paid and over-worked) health professionals struggling to keep their clinic, practice, or hospital open despite incredible odds that work against frontier medicine.

History of the Frontier Health Movement

"Up to and including 1880 the country had a frontier of settlement, but at present the unsettled area has been so broken into by isolated bodies of settlement that there can hardly be said to be a frontier line." This quotation from the US Census Bureau are the opening lines of Frederick Jackson Turner's 1893 essay, "The Significance of the Frontier in American History." Turner and the Census Bureau thought in terms of a national frontier line running north to south beyond which there were fewer than 2 people per square mile. After the 1890 Census this line was gone and Turner and the Census Bureau declared that the frontier was gone.

In 1984, the frontier was re-born. Frank Popper, a demographer in the Urban Studies Program at Rutgers University in New Jersey, published a series of articles which stated that the American frontier still existed. There was not a frontier line but a lot of frontier still remains. The 1980 Census found that there were 143 counties with fewer than 2 people per square mile and that these counties total 949,500 square miles - one quarter of the United States.

Even California, with four of the sixteen largest cities in the US, has 2 frontier counties that are 7 percent of the land area of the state - and this is using the less than two per square mile definition. According to the Bureau of Land Management (BLM), 383 million acres of federal public land - 17% of the US, and all in the West - have never been surveyed.

Using a frontier definition of less than six, there are 394 frontier counties and 45% of the land area of the US.

As Popper states in a 1984 paper, "For a place that is supposed to have disappeared generations ago, a lot of frontier is left. ...The frontier is off the beaten track: our national governing classes, as well as many of the rest of us, have no reason to notice it. At best, it is a place to fly over."

A Nebraska clinic adminstrator, Larry Jeter, read Popper's work with great interest. He felt that many national health policies did not recognize the differences beween frontier areas and rural areas. He began to contact western Regional Offices of the US Public Health Service and the National Rural Health Association to initiate dialogue on frontier health delivery issues.

A Public Health Service Frontier Task Force began to meet in December of 1985. The meetings of this group led to the adoption of Primary Care Activities in Frontier Areas, Regional Guidance Memorandum 86-10 by the Bureau of Health Care Delivery and Assistance (BHCDA), DHHS.

This policy - which will be explained in more detail in a minute - defines a frontier area and delineates funding and service issues for BHCDA programs; primarily the National Health Service Corps and Migrant and Community Health Center Programs (Sections 329 and 330 of the USPHS Act).

Frontier meetings have continued to take place either formally or informally among the people who are frontier activists, most recently though a Frontier Task Force convened by the National Rural Health Association. This Association recently approved a petition from members in frontier areas to establish a Frontier Constituency Group within its organizational structure.

DEFINITION

I. Difficulties in Establishing a Definition

It is not easy to define a frontier area. Last July the Congressional Office of Technology Assessment (OTA) issued a pamphlet called Defining "Rural" Areas: Impact on Health Care Policy and Research. This pamphlet analyzed the various governmental definitions of rural areas; Census Bureau, Department of Agriculture, Department of Health and Human Services, and Office of Management and Budget as well as non-governmental agencies and university-based research definitions.

The OTA paper states in the Summary:

> There is no uniformity in how rural areas are defined for purposes of Federal program administration or distribution of funds. Different designations may be used by the same agency. For example, Congress directed the Health Care Financing Administration to use Census' non-urbanized area designation to certify health facilities under the Rural Health Clinics Act, but to use OMB's MSA/nonMSA designations to categorize hospitals. ...
>
> There have been calls to develop a standard rural typology ... Although a standard typology may be desirable, it will be difficult to arrive at, because the different typologies have merit for various purposes.

Despite this statement, I believe that it is critical to develop a definition that clarifies what constitutes a frontier area. The definition will not be a single number but will rather consist of a matrix or series of screens to evaluate local conditions.

Too many people have heard of the frontier concept and seized upon the single number part of existing definitions. For example, 6 or fewer per square mile is used by BHCDA, in HRSA. In 1988, Congress passed "Section 799A. Health Care for Rural Areas," administered by the Bureau of Health Professions, HRSA, which provides funding for interdisciplinary allied health training programs in rural and frontier areas. This Act defines frontier as less than 7 per square mile.

The difference, on a county basis, between 6 or less and less than 7 is about 50 counties.

In order to standardize a frontier definition within Federal health programs, I have recommended that the Preamble to the Public Health Service Act be amended to establish a frontier category that will apply to all Public Health Service programs.

II. Essential Components of the Frontier Definition: The Issue is Access

1. Service Area/Catchment Area

The area to be served by the health or social service program needs to be defined. A service area makes the most sense if it can be organized around an existing trade or market area.

The services provided should be appropriate to the size of the population. The matrix entitled "Minimum Recommended Health Services" in the Attachments describes the types of services appropriate for a variety of population sizes.

2. Sub-County Units

Because of the large size of most frontier counties, it is important to develop a methodology for sub-county designations.

With current county-based designations, a single population center can elevate the population density above what is generally considered "frontier." In large, primarily, Western counties, the rest of the county is frequently very sparsely populated and is located 50-100 miles or more from the population center.

This is also true of other Federal designations like the Health Manpower Shortage Area (HMSA). The HMSA is based on a physician to population ratio within a county. The single large population center often has an adequate supply of health professionals but smaller communities at a great distance are not eligible for Federal personnel.

There is currently not a good data file for square mileage of sub-county units. We need a data source which will allow us to define a service area and be provided information on its square mileage. The US Geological Survey (USGS) may be the best source of this type of data.

3. Geographic Factors
Distance, climate, availability of transportation systems contribute to frontier status.

> Distance to existing or proposed services is the primary geographic factor. The services need to be appropriate for the population to be served.

For example, the BHCDA policy 86-10 says that a frontier primary care site will be 45 miles and/or 60 minutes average travel time to the next level of care and that this next level must be "a facility with 24-hour capability to handle an emergency cesarean section or a patient having a heart attack and some specialty mix to include at a minimum, OB, PED, IM, and anesthesia services."

4. State Involvement in Designation Process
It is very important to assure States' involvement in the frontier designation process. States have been assured participation in other types of designations. For example, the designation for the Medically Underserved Area, which is required for Migrant or Community Health Center funding states:

> The Secretary may designate a Medically Underserved population that does not meet the criteria established under paragraph (4) if the Chief Executive Officer of the state in which such population is located and local officials of such state recommend the designation of such population based on unusual local conditions which are a barrier to access or the availability of personal health services.
> PL 99-280, Health Services Amendments Act of 1986

Similar language should be included with a frontier designation, however with "frontier" we are designating areas not populations.

5. Universal Frontier Area Designation
This point is simple - a frontier area is a frontier area is a frontier area. Once an area has been designated as frontier for one program, it is frontier for all programs. A frontier designation defines an area not a population. We need to avoid the designation problems with many federal programs where you need to be an MUA for one program and a HMSA for another; the hospitals located in frontier areas are frontier hospitals, etc.

6. Appeals Process
It is very difficult to develop a cookie-cutter designation for a frontier area. Organizations should have the right to appeal a designation denial.

The BHCDA frontier policy 86-10 contains a statement which allows organizations to request a frontier designation. An expansion of this concept can provide the basis of an organizational appeal process:

> Because of the unique nature of frontier areas and the difficulty in developing eligibility criteria which fit all cases, there will be an opportunity for organizations to justify any unusual circumstances which may qualify them as frontier, for example, geography, exceptional economic conditions, or special health needs.
> Primary Care Activities in Frontier Areas - Regional Guidance Memorandum 86-10, Bureau of Health Care Delivery and Assistance, DHHS

RECOMMENDATIONS

FRONTIER PROGRAMS

1. NATIONAL CENTER AND CLEARINGHOUSE FOR FRONTIER HEALTH AND HUMAN SERVICES

In order to learn more about the existing health and social service programs in frontier areas, a National Center should be established to gather information and facilitate the sharing of information among programs. This National Center should be located in a frontier area and have an independent advisory board made up of both frontier providers of services and frontier residents/consumers.

An initial appropriation of $500,000 should be adequate to set up a National Center. Frontier people are used to "making do" and this project should be very reasonable to fund on an ongoing basis. In the long run this Center will save money because it will help to prevent duplication of services. Frontier programs will be able to learn of successful programs in other frontier areas as well as learning about which programs did not work.

Too many times, solutions proposed for frontier problems are programs or methods that worked in an urban setting. These solutions frequently fail when tried in a frontier area.

2. AMEND EXISTING LEGISLATION TO INCLUDE RECOGNITION AND CONSIDERATION OF THE SPECIAL NEEDS OF FRONTIER AREAS AND BUILD IN THESE CONSIDERATIONS TO ALL NEW HEALTH AND SOCIAL SERVICE LEGISLATION

There is already a considerable groundswell in the Congress to amend the Preamble to the Public Health Service Act so that all PHS programs will take into account the special needs of frontier areas. This should occur as soon as feasible. When this has been accomplished, other legislative needs will be proposed.

The National Center and Clearinghouse for Frontier Health and Human Services will provide the logical leadership and focal point for further legislative action.

3. FRONTIER DEMONSTRATION PROGRAM

Funds should be provided to establish a series of frontier demonstration projects leading to the development of appropriate frontier service delivery models. Integrated models that have systems to provide primary care, EMS, Primary Care Hospital (PCH), public health, mental health, and linkages to social services if not directly provided need to be developed and evaluated.

The call for integrated systems is coming very strongly from DHHS at this time. We need to assure that urban models are not developed and superimposed on frontier settings. In fact, if an succesful integrated system can work, overcoming all the difficulties inherent in frontier service delivery, that system could probably work anywhere.

4. PAYMENTS IN LIEU OF TAXES (PILTS) FOR HEALTH CARE

Because so much of the land in frontier areas belongs to the federal government and is not part of the local tax base, it is important to extend PILTS to help support the health care system in the areas. In most places PILTS now are paid to counties and used primarily for schools and roads.

EXISTING PROGRAMS

1. MEDICARE

Passage of legislation to allow for direct Medicare reimbursement of nurse practitioners.

Expand cost-based reimbursement program - Federally Qualified Health Center (FQHC) - to Medicare. Assure that National Health Service Corps sites are named in the legislation as federally qualified along with community and migrant health centers (Federally Funded Health Centers).

No increases in Medicare premiums, deductible or co-payment without application of means test. Increases are regressive and put a disproportionate burden on the low income elderly. They are already unable to pay their share. Writing off the deductible and co-payment place a tremendous financial burden on providers.

Allow Medicare to cover prescription drugs for low-income elderly.

Expand the preventive services covered by Medicare. In the long run, prevention will save millions of dollars and improve the quality of life for the elderly.

Amend the Clinical Laboratory Improvement Act of 1988 (CLIA 88) to remove financial obstacles to the maintenance of laboratories in frontier areas.

2. NATIONAL HEALTH SERVICE CORPS

Expand the National Health Service Corps. Assure that strong incentives are included to assure distribution of health professionals to frontier areas. Prioritize the free-standing National Health Service Corps sites, especially those in frontier areas. Legislate a specific frontier designation with its own appropriate criteria.

Expand the Loan Repayment Program; prioritize frontier and inner city sites for loan repayment candidates.

Encourage the education and training of physician, physician assistant, and nurse practitioner specialists in primary care gerontology. This will help with cost containment by reducing use of more costly physician specialists by the elderly.

3. MEDICAID

Amend Federally Qualified Health Centers legislation, which provides for cost-based Medicaid reimbursement, to include National Health Service Corps sites for eligibility retroactive to April 1, 1990 along with community and migrant health centers (Federally Funded Health Centers).

Expand eligibility to Medicaid. Allow 2-parent poverty level households to qualify.

PROGRAMS FOR THE FUTURE

A wide array of health and social service programs are needed to improve the quality of life for frontier and rural elderly. Some of the areas needing immediate attention are transportation, housing, adult day care and home care programs, meals programs to assure adequate nutrition, access to the entire spectrum of physical and mental health care services and the establishment of social support systems. People should not have to spend their older years in isolation, separated from family and friends.

SUMMARY

Thank you again for the opportunity to share ideas on the problems and some possible solutions to frontier health and social service needs. I cannot take sole credit for these ideas because there is a dedicated group of health care professionals who have gone to meetings, developed position papers, and advocated for the unique needs of frontier areas for a number of years. It has been an honor to be a part of this effort.

In addition to my testimony, I am submitting additional materials to serve as background information which I hope will prove helpful to future policy development.**

**See Appendix--Item 1.

Senator SIMPSON. Thank you very much. That is very impressive testimony.

Let me just ask a few questions, if I may.

Mary, in your task as a home health care consultant through the Department, how long have you been working in this field in Wyoming?

Ms. NETZNER. For 15 years.

Senator SIMPSON. And these little cameos that you present from real life, are they usual, in your experience? Those are different, but usual, are they, in a sense?

Ms. NETZNER. They are very usual, yes.

Senator SIMPSON. And from what I think you are saying, and from the testimony I read last night, it seems that many of these people in Wyoming are getting the help they desperately need, only because staff is willing to go the extra mile—sometimes beyond anything required or even anticipated by Federal policy. Is that correct?

Ms. NETZNER. Yes. We have a very supportive network in the communities. Everybody, not just the agencies, goes beyond what is expected.

Senator SIMPSON. And that is sometimes when the comment comes from the Federal authorities, as you do that? Is that correct?

Ms. NETZNER. Yes.

Senator SIMPSON. When you avoid their activities of preciseness that just don't fit Wyoming?

Ms. NETZNER. Yes, we have to take them out of one program and into another.

Senator SIMPSON. Flexibility is what we are seeking in the Federal law, and that's what you are trying to do without the Federal law right now.

Ms. NETZNER. Right.

Senator SIMPSON. Mr. Heinlein, you dramatically present that. I often say there are only 34 communities in Wyoming that play 11-man football. That kind of surprises people, but that's the way it is.

When you use this term "census designated places," what again does that mean, for the record?

Mr. HEINLEIN. A census designated place is either an incorporated town, city, borough, something like that, that has corporate limits, or an area, a cluster of people living together that are not incorporated but have a population of at least 1,000. According to the statistics that I have, Warren Air Base, which is not a part of Cheyenne, is a census designated place, and I believe Jeffrey City is also listed as a census designated place.

It is a cluster of people. But 29 percent of our population lives someplace other than incorporated areas or census designated places.

Senator SIMPSON. That is the 29 percent of Wyoming's population who, according to statistics and the U.S. Bureau of Census "don't live anywhere?"

Mr. HEINLEIN. That's correct, Senator.

Senator SIMPSON. Is that really it?

Mr. HEINLEIN. Right. They are outside the main places of the 101 named places. That's correct.

Senator SIMPSON. Which of Wyoming's counties exceeds the six people per square mile ratio?

Mr. HEINLEIN. If we go by the 1990 DAFC population estimates, which the Division of Administration of Fiscal Control, it is Albany, Campbell has just over six, Goshen County also just over six, Laramie County, Natrona County, Sheridan, and Uinta Counties.

Senator SIMPSON. There's the point. Folks that live on the edges of these urban areas within small counties—the access issue is the problem. Do you think the counties are the most useful unit to use for analysis here, or do we need something smaller—a sub-county unit?

Mr. HEINLEIN. I would concur. Something smaller than that does make sense. If we look, for example, at Laramie County, with a population density of 26.8 per square mile, if you blipped out Cheyenne, Laramie County would change significantly. So for a Pine Bluffs, Carpenter, and all of those, it is very much a different world than it is for Cheyenne or even for someone like myself who is not in the county, but I ride my bicycle to work in the center of the city. It's a different ball game in the other parts of the county.

Senator SIMPSON. Thank you.

Carol Miller, again, thank you so much. Based on your long experience, why do you think the advocates of frontier areas are simply not heard, or not widely heard? What is it?

Ms. MILLER. I think that we are so accustomed to helping ourselves that we have not gotten it into our heads yet that we have to get out there and raise these issues. I feel very fortunate that the clinic where I work, which had been ignored by the Federal Government for a long time, the board finally just said we had to go out and talk about what was happening. Over the past decade what happened was that physicians left the areas, as you mentioned, to go to more high-tech settings.

We were not able to recruit. There were no programs. We can't get registered nurses. We are hoping to be able to begin providing home care. People just relied on themselves and relied on their neighbors.

I hope that the national tide will turn, because we are just too important to the national economy, to be ignored. Also, there are a lot of people in frontier areas. Our programs are very cost-effective.

When I worked for the Federal Government, I found that in frontier areas the average clinic got a subsidy of between $60,000 and $70,000. That mostly paid the mid-level nurse practitioner or the physician assistant salary, which could not be made when providing care to low income people.

In larger places, people are more used to the social service system, they are used to getting more help from the Government. There are Federal clinics that get $7 million. I can give an example. Region 8 covers all the Rocky Mountain States. It gets about $11 million, $7 million in the community health center program stay in Denver. All the rest of the States in the region divide up everything else. I would say there is something wrong there.

One final comment, a lot of programs do not even let frontier areas participate. For example, the National Health Service Corps—I know of a doctor in New Mexico who is the only doctor in a large county who also works in their small hospital. The Federal Government has told her that when she leaves, the county will qualify for Federal assistance, but as long as she is there, she disqualifies the whole county.

It is a real Catch-22, and I know it is happening all over.

Senator SIMPSON. That is one of the things we will have to get reestablished. Senator Durenberger has always been a great advocate of rural health care. With his help, we did, last November, finally create an awareness of rural versus urban, a small step. Now we can push that a step further and develop that same awareness of the "frontier," and people like you, with your vast background can help us do that. This use of a frontier demonstration project is of interest to me.

You mentioned that, and the PILTS program, payment in lieu of taxes, is fully incomprehensible to people in the East. They don't understand what that means. But it is very important here, with non-Federal land. So your suggestion to use those funds for PILTS is very helpful. I think it is a case of awareness, but there is this issue of rugged independence. The cattlemen don't ever ask for money from the farm program, and they go up and down like yo-yos, and in and out of business. That is a part of our trait. You know the Rocky Mountains from living here.

This is very helpful material to us, and it is all on the record and will be presented to the staff and to the Chairman of the committee. I thank you all very much. This has been very helpful.

We will now hear from Dr. Larry Meuli, Administrator of the Health and Medical Services of Wyoming. He is responsible for administering all State and federally funded health programs throughout the State of Wyoming. He was the Director of Family Health Services for the State, has a distinguished academic background, and serves as President of the Wyoming Chapter of the American Academy of Pediatrics Practice, practiced at Missoula and Loveland, and chaired the Department of Pediatrics at Children's Medical Center in Tulsa, and is a delegate to the Wyoming Medical Society. He is very active, and very accessible—I have found him so. I know this is a special effort for you, I know of the illness of your wife, and we wish her full recovery. I know that's a troublesome personal issue, and I hope she is doing much better. We pray for that.

Dr. MEULI. Thank you, Senator.

Senator SIMPSON. We have Evonne Ulmer, from Weston County Hospital in Newcastle. She oversees all aspects of administration and planning and acute care at that small hospital. She has developed a number of innovative successful projects at the facilities in diversified care. She has her degree in nursing from St. Luke's School of Nursing in Duluth, and St. Joseph's in Maine, and a Master's in Health Administration. She has been deeply involved in Newcastle, including being a member of the board of the Wyoming Health Care Association, a member of the rural task force. She and I have often visited in Washington, and she is a very able lady.

We also have Dr. David Driggers here. He is the Director of the Natrona County Family Practice, Program Director for the University of Wyoming Family Practice Residency Program. That is a very important thing. He is responsible for training a large number of the physicians who will practice in the most isolated and remote regions of the State, hopefully. That doesn't always work.

He received his Bachelor of Science from the U.S. Air Force Academy, his M.D. from the Medical College of Georgia. He has been practicing in Casper for the past 10 years, and has done numerous research papers, written articles on the sweeping range of medical topics from pediatrics to geriatrics. He is Associate Dean of the College of Health Sciences at the University of Wyoming, and Chairman of the Central Wyoming Cooperative Board of Higher Education, active member of the American Academy of Family Physicians, and the Wyoming Medical Society.

If this distinguished panel will proceed in that order, within the time constraints as previously explained. We appreciate all of you being here very much.

STATEMENT OF DR. LARRY MEULI, M.D., ADMINISTRATOR OF HEALTH AND MEDICAL SERVICES, STATE OF WYOMING

Dr. MEULI. Senator Simpson, thank you very much for inviting us to participate in this panel, and to provide testimony regarding rural health and frontier health issues.

As Ken Heinlein explained earlier, in the 1990 Census, when you look at Wyoming, seven of our counties are rural, 16 of our counties are frontier—they don't even meet the rural definition. By the census of 1980, it was actually five rural counties, and the rest were all frontier.

The frontier is a concept that is just beginning to be recognized. I think the frontier is as uniquely different from rural as rural is from urban. Ken Heinlein set the stage for the fact that our health care facilities licensure and survey team that surveys hospitals around the State, has 27 acute care hospitals in the State of Wyoming to survey.

When we presented our transportation budget to the central HCFA office, it was interesting—this was several years ago—they slashed our budget by about 50 percent. When asked for an explanation, the explanation was that Delaware has 27 acute care hospitals, and they don't need that kind of a travel budget.

As explained earlier, if you look at our 27 hospitals, each of the hospitals cover a geographic area one and a half times the size of the State of Delaware. So we did need a little larger transportation budget.

As I go through this, I want to talk briefly about our public health nursing services, our health care facility licensure and survey program, our WIC program, our AIDS and STD program, our maternal and child health block grant, and a little bit about access to care. Some of these do not directly apply to the elderly, but certainly a great number of these issues do.

In Wyoming, most of our public health nursing agencies and WIC agencies are co-located. They do a wide variety of tasks, and

in many cases are the primary entry point for people into the health care system. The public health nurses provide services from home health visits to the elderly, to the high risk mother, to the infant, to the immunization clinics, they provide disease followup, and a lot of education classes, plus a number of other things. This is entirely different from what public health nurses do in an urban area.

This emphasizes the expanded role of the public health nurses in frontier States, like Wyoming. Therefore, many of the stringent rules and regulations that are written for Medicare, for laboratory licensure, for maternal and child health projects, and for home health care agencies adversely impact our ability to provide those services in one community agency. Again, we combine things, the Federal Government tends to divide things.

I see what is happening, that the rules and regulations apply to areas where there is a concern about duplication of services. In Wyoming our major concern is gaps in services.

To give you some examples, a home health nurse and a therapist in an urban agency—in a metropolitan area—can average six to eight visits per day. In a rural agency, they can average about four visits a day. But when you get into a frontier area, where you are talking about long distances, they only average about two and a half visits per day. However, when reimbursement is considered, reimbursement is based on the whole across the Nation, the national average. So the time spent in administration and travel is not considered in the reimbursement situation.

Another regulation that our public health nurses are faced with is that nurse aides making home visits, as Mary Netzner mentioned earlier, have to be able to contact their supervisory nurse by telephone. If we are unable to fulfill that requirement and if it is strictly enforced, then as she said, about one-third of our home health agencies will be decertified in the State of Wyoming, so there will be no services available for home health care for the elderly.

The other thing is that our sparse population makes for a very small case load in many of our communities. Because of that, our home health aides and homemakers many times are underutilized and underemployed. Therefore, our aide turnover is relatively high. There are now new requirements coming in that aides have to be certified and have to meet minimum requirements to work in a certified agency. Again, this is going to impact us very directly, because it is going to be difficult for those aides to become certified in a frontier area, and with the high turnover rate, we will again have big gaps in services.

The Wyoming Medical Facility Survey Teams are teams that survey hospitals, nursing homes and other health care facilities, and they travel approximately 155,000 miles a year. They spend approximately 40 hours per month on the road. Again, when you start with the reimbursement formula, that kind of road time is not reimbursed. It is the amount of time that is spent in the facility that is reimbursed.

You can see that it makes it difficult for us to obtain and retain personnel. They are away from their offices 85 to 90 percent of the

time. Much of the time they are on the road, because of the great distances involved.

Another thing we are concerned about is the nurses aide training that is going to be required for the nursing homes. They have to be trained in a deficiency-free facility. In the United States there are only about 300 of these nationally. There is none in Wyoming, so it makes it difficult for these aides to receive their training.

Another thing under the present law is the pre-admissions screening and annual resident review (PASARR). That has to do with patients being admitted to long-term care facilities, to nursing homes, having to go through that review. If they have mental illness or are developmentally delayed, the nursing home is required to see that those patients get active treatment. In many of our small communities, the professionals are not there to provide that active treatment, so that necessitates that some of these people end up going to the State Hospital in Evanston or the State training school in Lander, a long way from their support system. That placement may not be in their best interests, but to follow the Federal guidelines, we are required to do that.

I want to talk briefly about the WIC program. I know this is a mothers, infants, and children program which does not directly involve the elderly, but I want to make some points about how this is difficult for us.

Our WIC services are provided through 15 local agencies and 39 outlying agencies. Some of the clinics we provide through the WIC program, we are only able to be there every month, or every other month. For example, areas like Sundance, Newcastle, Lusk, Hannock, Afton, Pinedale, etc., have clinics either monthly or bimonthly. Regulations require that we provide service, expedited services within 10 days to newly diagnosed pregnant women and infants admitted to the program. However, it may take 30 to 60 days for us to have a clinic in the area where that mother is located.

Consequently, for us to fulfill the guidelines, that mother may have to drive 45 to 100 miles to meet that 10-day requirement at another one of our clinics, to become certified. This does not seem to be reasonable.

Another requirement we are under is that we get referrals of pregnant mothers to clinics to treat smoking and substance abuse. In many of our small communities, there are no programs like this, and we cannot fulfill that requirement.

Another interesting requirement for the WIC program is what is called vendor monitoring, which means that we are required to see that the grocery stores who are providing the food staples for the WIC mothers and children are providing it accurately and are doing it efficiently, and there is no fraud or abuse involved.

The Federal guidelines say that to do this, we have to do covert operations, to test these grocery stores, to see if they are doing it correctly. Can you imagine going into a grocery store in a place like Frannie and doing a covert operation? Frannie has maybe five or six people that are on the WIC program, and represent maybe two or three families. The grocer knows everybody within a 50-mile radius. There is no way we can do that.

We have a lot of communities exactly like that. Even in Laramie, WY, where the WIC program did a pilot of this to see if we could slip in a disguised WIC participant to check out the food staples in

that store, to see if there was any abuse, the second time this woman went to that store, she was immediately recognized and called by her name. So that shot down that whole thing.

The other thing about this is that it is a kind of entrapment that is not well received in Wyoming. We have been above board and tried to educate our vendors and be straightforward with them, and assume that they are innocent people and doing a good job. When you come in with a covert operation like this, it is very detrimental to your program when you are trying to build cooperative relationships with them.

I want to talk briefly about our sexually transmitted disease and AIDS program. Frontier communities are experiencing significant declines in morbidity for gonorrhea and for early syphilis. The thing we are seeing most of in Wyoming is chlamydia. Chlamydia infections are a type of sexually transmitted disease. It has increased two- or three-fold in Wyoming. However, the national priorities and the national emphasis is on gonorrhea. Consequently, we can't access those funds, because we have the wrong disease in Wyoming.

Therefore, we can expand our public health resources for one disease that is considered a national concern, but do not have the flexibility in disease prevention program grants to appropriately respond to frontier community public health needs.

In most cases in Wyoming, treatment for reportable diseases is through the private sector, not the public health sector, and we do not have the resources nor the personnel nor the clinics to adequately treat these diseases in the public sector. Therefore, we can identify the diseases, we just don't have the money to treat them and we have this cooperative agreement with the private sector, which is unique to a frontier area like Wyoming.

In consideration of grants for the AIDS program, many of the grants are becoming categorical grants. When they become categorical, that means that the grants are let for minority populations, for homosexual or bisexual males, for the homeless, for migrants, for specific population groups. In Wyoming, we cannot compete effectively for these grants, because we don't have enough people that fall into these categories to obtain the money. We would probably have to advertise to get those people, and I'm not sure how many people would respond to the ads.

Senator SIMPSON. Dr. Meuli, if you could just do one more minute, so that we can keep to our schedule.

Dr. MEULI. Thank you.

The maternal and child health block grants for us are much preferable to the categorical grants, and we feel that that money can be much better utilized in that way.

The last issue is access to care. In Wyoming, it is difficult for us to talk about access to care. When we consider health manpower shortage areas in the State of Wyoming, there are seven criteria set up to designate these areas, and four of the criteria actually disadvantage us, so that we can't compete effectively to be designated as health manpower shortage areas. It is difficult for us to get doctors from the National Service Corps to serve in our smaller communities.

Thank you very much for your time and attention.

[The prepared statement of Dr. Meuli follows:]

THE STATE OF WYOMING

MIKE SULLIVAN
GOVERNOR

Department of Health and Social Services

Division of Health and Medical Services

HATHAWAY BUILDING CHEYENNE, WYOMING 82002

TESTIMONY PRESENTED TO THE SPECIAL COMMITTEE ON AGING

Roberts Commons
Casper College

July 23, 1990
9:30 a.m.

Senator Simpson and members of Special Committee on Aging:

It is a privilege for me to have this opportunity to provide testimony on rural and frontier health issues. According to the U.S. Census Bureau, frontier is considered as less than 6 people per square mile. In Wyoming, according to 1980 census, we have five counties that are considered rural. The other eighteen counties are frontier. Frontier is a concept that is beginning to be recognized and from my point of view is as uniquely different from rural as rural is from urban. Federal rules and regulations are written to avoid duplication of services. In Wyoming the problem is not duplication of services, but gaps in services. Federal rules and regulations are designed for urban or metropolitan areas resulting in disadvantages for frontier areas.

An example of our uniqueness as a frontier area is exemplified by our Health Care Facilities Licensure and Survey Team which has 27 acute care hospitals in Wyoming to survey. Several years ago, when we presented our survey budget to the HCFA central office, our transportation budget was slashed in half. When asked for an explanation, the central office noted that Delaware had 27 acute care hospitals and they didn't need that large a transportation budget. The point is that each of our hospitals serves a geographical area 1 1/2 times the size of the state of Delaware. Sometimes, it is difficult for people from the east to grasp that concept.

Public Health Nursing

In Wyoming, most Public Health Nursing agencies and WIC agencies are co-located and do a wide variety of tasks and many times are the primary entry points for people into the health care system. The public health nurses in the counties provide services from home health visits to immunization clinics to disease follow up to education classes for the elderly and for high risk mothers and their infants. They provide well child care nursing assessments, immunizations, STD counselling and partner notification. In some agencies, they do family planning and child birth education classes. They may be on the child abuse team and do nursing assessments and follow up on abused patients. They also do screening tests such as hematocrits to assess anemia and in some cases cholesterol screening, plus general health care counselling. They also follow children with special health care needs and get people enrolled in the Medicaid system along with their counterparts in the Division of Public Assistance and Social Services. They become a referral source for the various medical and social programs in a community. This emphasizes the expanded role of public health nurses in frontier states like Wyoming as compared to public health nurses in many metropolitan areas that only do immunizations. Therefore, the stringent rules and regulations written for HCFA regulated laboratories, Maternal and Child Health and home health care agencies adversely impact our ability to provide expanded community based services out of one

agency in a flexible manner. The delivery of home based services, including certified home health care is very costly due to travel and administrative costs and in some cases is impossible. For example, a home health nurse and a therapist in an urban agency can average 6-8 visits per day and a rural agency may average 4 visits per day. However, in a frontier agency it is not unusual to average 2.5 visits per day because of the extensive travel involved. Medicare and insurance reimbursement is the same for all agencies and does not pay for this additional cost for time or travel. If the agency is not subsidized adequately with state or local funding, then the service will not be available to our isolated citizens.

Another regulation has to do with nurse aides making home visits. One of the regulations requires that the aide be able to contact a supervisory nurse when they are in the patient's home. In frontier areas like Wyoming, many poor homes have no phone. The home health agency may have only one nurse and she may be making home visits at the same time and there are no phones in the nurse's car. This requirement then may not be met in a frontier area so these patients may not be able to receive care. If the regulations are strictly enforced, about 1/3 of our public health nursing agencies doing home health care would be decertified for that service.

The smallest and most isolated communities in Wyoming find recruitment of qualified professional staff difficult and in most cases impossible. The shortage of RNs, PTs, OTs, medical social workers, and speech therapists affects quality and availability of services to our communities. Federal reimbursement does not provide payment that allows agencies to provide salary incentives to professionals willing to consider frontier areas. In many small communities, a therapist will work for the hospital, nursing home, school and home health agencies in order to maintain an adequate caseload. Reimbursement does not cover the additional cost of time, travel and administration between agencies in the communities.

This sparse population also results in a very small caseload for home health aides making it difficult to retain their services to agencies because of limited clientele. Because they are "underemployed or under-utilized" aide turnover is high and the new costs of certification and the 75 hours of required training will be difficult to absorb. These costs may result in the loss of home health aide services in frontier areas.

<u>The Wyoming Medical Facilities Survey Team</u>

The Wyoming Medical Facilities Survey Teams do Medicare/Medicaid surveys. We have 121 providers which we survey. The survey teams travel approximately 155,000 miles per year and each surveyor spends approximately 40 hours per month on the road. They spend about 85% - 90% of their time outside of their offices because of the lack of qualified personnel available to do these surveys and the great distances involved. The grant formula doesn't reimburse adequately.

The OBRA '87 Act which includes the nursing home reforms is causing us concern. Since the regulations have not been finalized, it is difficult to implement them. However, the proposed regulations for nurses' aide training will require that nurses' aides be trained in a deficiency free facility. At the present time there are none available in Wyoming and there are only 300 hundred available nationally. Therefore, training to qualify these aides will be difficult to accomplish.

There is also a requirement that 5% of the nursing homes surveys in the state be validated by a HCFA look behind survey with a minimum of 5 nursing homes. In Wyoming, this minimum of 5 nursing homes means that approximately 15% of the nursing homes will have a federal look behind survey. It appears that the amount of time it will take to survey a nursing home will increase from about 40% to 65%. There does not seem to be any improvement in patient outcomes or resident care provided by the extra time spent in doing the survey. This prolongs the survey, and what more, means that our surveyors will be out of their offices for longer periods of time.

The Preadmission Review System (PASARR) for nursing homes require active treatment for anyone with a diagnosis of mental illness or developmental delays. Many frontier communities have limited professionals available for this treatment. This may necessitate patient transfers to the Wyoming State Training School in Lander or the Wyoming State Hospital in Evanston which removes the patient from their local support system. In those cases, the local nursing home may be the best placement for the patient.

Concerns Regarding the WIC Program

Wyoming WIC services are provided through 15 local agencies to 39 Wyoming communities. In brief, 1/3 of these community services are limited to once a month or once every other month. For example, Sundance, Newcastle, Lusk, Hanna, Afton, Pinedale, Greybull, Midwest and Buffalo have clinics either monthly or bimonthly. Regulations require that we provide expedited service within ten days to new pregnant women and infants admitted to the program. However, it may take 30-60 days before the next clinic is scheduled and the applicant is screened. The nearest project is frequently 45 to 100 miles away which means the client has to travel great distances to make the mandated time limit. Another requirement is referrals of pregnant women to clinics to treat smoking and substance abuse. However, in many communities in Wyoming, there are no agencies which offer these programs.

Vendor Monitoring

USDA requires compliance by testing the vendors to determine if they are abusing the WIC Program. To do a covert series of purchases to determine abuse when the grocer personally knows all the participants in a 50 mile radius is difficult. For example, there are at least four communities in Wyoming with a single vendor with less than 500 population in those communities and they serve approximately 5-10 WIC participants from 2 or 3 families. It will be extremely difficult to do a covert check of abuses in those stores. Furthermore, even at one of our larger communities, Laramie, Wyoming with several vendors, the WIC Program tried a covert operation which was unsuccessful, as the second time our disguised WIC recipient went into the grocery store, she was immediately recognized.

This kind of entrapment is not well received in Wyoming. Our WIC program has tried to be up front in educating our recipients and vendors and have assumed people innocent until proven guilty. Therefore, we find this type of activity detrimental to our program.

Weather conditions in Wyoming can change frequently. So therefore, clinics scheduled in remote areas may need to be canceled because of adverse weather conditions. However, because a clinic may not be held in a community for another 30-60 days the clinics are convened even though it may be unsafe and impractical for the participants and the staff to arrive in adverse weather conditions.

Sexually Transmitted Disease Program

Our Sexually Transmitted Disease Program has the following difficulties. While frontier communities are experiencing significant declines in reported morbidity for gonorrhea and early syphilis, the reported morbidity for chlamydia appears to be increasing 2 to 3 fold yearly. The national STD program grants do not permit or advocate for frontier states that need flexibility in directing available grant resources for the most current local disease control problem. The federally funded programs continue to direct the majority of their resources to national mandates focused on the average metropolitan experiences, for example, gonorrhea. In brief, we have resources to support detection for gonorrhea through screening, patient counselling and education, partner notification and referral, but have limited treatment funding for gonorrhea infections. We can expand our public health resources for one disease considered a national concern, i.e. gonorrhea, but do not have the flexibility in disease prevention program grants to appropriately respond to frontier community public health needs such as chlamydia. In most cases in Wyoming, treatment for reportable diseases is through the private sector. We do not have the resources nor the personnel nor the clinics to treat these diseases in the public sector.

Categorical grants, e.g, in the AIDS Program, that are designated for the homeless, minorities, and specialized population groups such as homosexual/bisexual males and drug abusers are difficult to obtain for a frontier state. This is especially true when several restrictions are placed on these grants, e.g., homeless drug abusers. Our numbers are so low and our population so widespread, that it is impossible for us to even consider such categorical grants. We would have to advertise statewide to find such an individual. However, our AIDS patients suffer just as much and die as frequently as those in metropolitan areas who get most of the resources because they are well publicized.

The MCH SPRANS Grants

The MCH SPRANS Grants (Special Projects of Regional and National Significance) are difficult for a frontier state to obtain because of the small population numbers involved. The federal requirements for need's assessments and specific data requirements make it difficult for frontier states or their sub-units to write grants and meet the guidelines of the maternal and child health requirements. We strongly recommend that the amount of the set aside for the MCH grants be decreased. Frontier states do not have the resources to hire full time grant writers and send them to the appropriate institutes to learn the grant writing jargon which makes our grant proposals competitive. The cost of employees who process and review the grants is significant. It seems the money could be better spent by the individual states as part of their block grant monies.

The MCH block grant is preferable to categorical grants. For example, in the late 70's Wyoming received $120,000 to do the following categorical programs on a statewide basis: 1) The Child and Youth Program; 2) The Maternal and Infant Program; 3) A Dental Health Program; 4) A Family Planning Program, and; 5) A Genetic Program. To imply that this amount of money could serve a state geographically as large as Wyoming in all of these areas was ludicrous. To efficiently utilize this money, it was all spent in one public health nursing clinic in our state that had the resources to adequately address these categories and had the pediatricians and obstetricians to provide medical consultation to the program. Fifteen thousand dollars of this money was identified for the treatment of high risk mothers. By limiting access to unmarried pregnant women 14 years of age or younger in one county, we were able to serve about 2-3 patients per year without overspending the budget. This is an example of the administrative manipulations one has to go through to effectively utilize a categorical grant in a frontier state.

To alleviate the problem of lack of medical specialists in a community we provide intermittent clinics with specialist in the larger communities in Wyoming, e.g., pediatric cardiac clinics. However, this does necessitate significant travel for outlying families to attend our specialty clinics in a frontier state. However, the patients' travel time is greatly increased if they have to travel to a university medical center for health care. Specific examples of the needs in frontier areas include the transport of newborns and high risk pregnant women to university centers and the transport of patients to specific specialty clinics at level III centers or to the larger communities in Wyoming for their health care.

The Area Health Education Center Grants (AHEC) require they be funneled through a medical school, which is difficult for Wyoming to obtain because there are no medical schools in Wyoming.

Access to Care Issues

I would like to briefly address National Health Service Corps Providers that are to be sent to medically underserved areas. Interestingly, for 1991, Wyoming has only one health manpower shortage area (HMSA) designation from the National Health Service Corp and that is in the Greybull/Basin area of Wyoming. There are 520 designated areas with vacancies in the United States and Region VIII was allotted 44 positions, which is about 8.3% of the total. This is a significant number of designations given the small population in Region VIII. However, a frontier state like Wyoming should have more than one designated area. The point system for selecting these designated areas is set up in such a way that it discriminates against a frontier state like Wyoming that truly needs additional physicians.

The criteria that is utilized to develop the health manpower shortage vacancy list are as follow: 1) The infant mortality rate; 2) Percent of the population with incomes below 200% of the poverty level; 3) The population-to-primary care physician ratio; 4) Percent of minority population; 5) Percent of special populations which include the homeless, migrant and seasonal farm workers, perinatal problems, persons with HIV/AIDS, substance abusers and/or elderly person served by a site; 6) Vacancies as a percent of total budgeted staff, and; 7) The degree of rurality. Each criteria defined is given a point total from 0 to 4. Each area is then assessed according to the total number of points that area receives. The higher the point total, the greater the need. With a maximum of 32 points for each area, Region VIII was allocated 44 vacancies. The cutoff point for Region VIII was 20 points or greater to be eligible as a designated health manpower shortage area. No sites in Wyoming obtained that many points, however, Greybull had 19 points so was selected as a token gesture to Wyoming.

Four of the seven criteria utilized to designate HMSA discriminate against frontier states, because of our small numbers and lack of minorities and special populations. Only one criteria actually benefits a frontier state and that is the degree of rurality in which frontier states score high. Because our minority population is only about 5% of the state population and because our infant mortality rates are based on caucasian populations and because we do not have specialty populations or county wide pockets of poverty, we do not score well using these criteria.

Our population to primary physicians ratio is very high, but the distance to primary care physicians should also be factored into the equation. The population to primary care physician ratio is adversely impacted if the geographical areas are county wide. In many counties there may be enough physicians in the major community in the county but not in the outlying county areas.

Wyoming has three areas designated for rural health clinics, however, none of the three areas at the present time have the professional personnel to keep the clinics open. These clinics have been operated by physicians assistants under the supervision of a primary care physician. However, at present there are no physicians assistants available to operate these clinics. For example, the clinic in Dubois, WY has just closed. That necessitates people driving 75 miles to receive primary care at the next closest community, which is Lander, WY. This again demonstrates the difficulty we have of obtaining and retaining professional health care providers in our state and the great distances that one has to travel to the next medical care facility.

As we review the hospitals in Wyoming, 12 of Wyoming's 27 acute care hospitals reported deficits in 1987. Sixteen (16) of Wyoming's 27 hospitals have less than 50 beds, 4 have less than 25 beds and only 5 hospitals have over 100 beds. When you look at the annual occupancy rate, only one of those 27 hospitals has an occupancy rate greater than 50%. In most communities, the hospital is the second largest employer; therefore, it has a significant economical impact in those communities. The concern is, if the community hospital fails, and as noted 12 of them are losing money, then those communities may have to close their hospital doors.

There needs to be incentives to attract physicians to frontier areas and to keep frontier hospitals operational and viable. Many health care providers are attracted to communities because of their hospitals. There is a concern that physicians will leave communities without hospitals which will then leave these communities without medical services. This then necessitates individuals driving from 50-100 miles or further for hospital or medical care making our health care access problems ever more acute.

The State of Wyoming has lost 23 physicians in the past year and reportedly now has 541 actively practicing physicians in the state. This amounts to one actively practicing physician for about every 892 patients. In '86 the national average was one physician for every 444 patients. The total number of physicians living in the State of Wyoming in '89 was 656. As noted, many of those are not actively practicing; however, if you take that total, that still accounts for only one physician for every 736 patients. The problem in frontier states is not a duplication of services but gaps in services. It is difficult to recruit physicians to frontier areas because of isolation, lack of 24 hour coverage, lack of association with peers and colleagues, which makes ongoing education difficult plus many community hospitals are perceived as lacking high tech, diagnostic and treatment capabilities. Therefore, citizens bypass the local hospital to go to other communities except in time of emergency when distant travel is difficult. At those times they want a fully staffed and equipped hospital.

Thank you for allowing me to comment on the uniqueness of frontier states.

Sincerely,

R. L. Meuli m.d.

R. Larry Meuli, M.D., Administrator
Division of Health and Medical Services
Wyoming State Health Officer

RLM/dp

Senator SIMPSON. Dr. Meuli, thank you. Your entire statement will be a part of the record of the committee. I appreciate it very much.

Now Evonne Ulmer, please.

STATEMENT OF EVONNE ULMER, ADMINISTRATOR, WESTON COUNTY HOSPITAL, NEWCASTLE, WY, CHAIRMAN, WYOMING HOSPITAL ASSOCIATION

Ms. ULMER. Thank you, Senator Simpson, for allowing me to come and testify today.

One of the many duties I do in my spare time is serve on the governing council for the American Hospital Association for Small or Rural Hospitals. I am a representative of the Rocky Mountain Region on a governing council of about 20 people. It is very apparent in my dealings with my peers across the United States that rural is not rural is not rural.

This becomes evident when you think about my trip in today, in order to testify. I drove 177 miles. I drove through two small communities on the way, the only communities until I got to Casper. Neither of these communities had 24-hour health services. This is considerably different than and what I hear from people that are in Pennsylvania or Maryland or some of the other areas that I talk to.

In looking at the extent of the problem, I was thinking not so much about the distances I was traveling but what would be on my desk when I get home this afternoon. Some of the things I need to deal with are lack of transportation—I understand from the news clipping that Newcastle will be losing some of its bus service. I wonder how I am going to get items such as drug service from Denver now, and more importantly, what am I going to do when I need emergency supplies that I have been getting from Rapid City on a daily basis, or sometimes a weekly basis on the bus.

I also have a resignation from a nurse on my desk. This resignation puts me two nurses down on my staffing, and makes a 16-percent vacancy rate on my staff. You can understand the limited resources we are dealing with in our rural hospitals.

I also have a problem with one of the residents in my nursing home who needs a dermatologist consultation. She is not ambulatory, she is confused and somewhat combatant. I have to determine how to get her 90 miles from Newcastle to Rapid City to get the services she needs.

So these are some of the rather unique kinds of problems. They really are not unique to Wyoming. Dr. Meuli pointed out some of the examples I have used in my written testimony of the kinds of problems that become apparent when you try to deliver health services in such a vast geographic area with limited volume and limited resources. The Federal Government's policies frequently do not address the differences.

Some of the examples I have written down, I think HCFA could do a better job of analyzing impact analysis, looking at the effects on rural areas. Right now, we are dealing with some regulations

called CLIA regulations, which regulate laboratory services. If I understand the proposed regulations correctly, I am very concerned that our hospital will be classified as a Level 2 lab, and that most hospitals will be because of the nature of being a hospital.

They have requirements for medical directors that I am not sure I can meet. I get a pathologist from Rapid City to come once a month. Whether HCFA will determine whether that is adequate or not worries me.

I am also worried about the level of staffing and education for the technologists. I have three lab technicians in my hospital, one of which is HHS certified, which meets Medicare requirements. That program is no longer in existence. According to the regulations, the supervisor can't be sick or take a vacation, because she is supposed to be available to review the work of my other lab techs on the next working day.

I understand the need to provide accurate lab services, and certainly that is an issue of concern. We also need to look at what happens if the lab is closed down because they can't meet these requirements, and what happens to health care or the hospital care in Newcastle if that should come about. Dr. Meuli already talked about the OBRA requirements for training our nursing aides for nursing homes. That's another significant concern. The closest place to train would probably be Gillette, which is 90 miles away.

All of the regulations that require certain educational degrees, a certain number of hours of service, or a certain level of education become problems in frontier areas because of the lack of access to those types of resources. In putting together my testimony, I talked to a number of hospital administrators across Wyoming. I got little vignettes of the kinds of difficulties that have become apparent recently to them as examples of this.

Douglas is trying to establish a medical clinic in Glenrock, which is currently not served by a physician. They are trying to use the Rural Health Care Clinic Act in order to enable them to do it.

However, the clinic requires that they have at least a half-time physician assistant or nurse practitioner. The amount of the population base to serve that is not adequate. Therefore, the clinic becomes non-cost effective.

Home health requirements—we heard about some of the problems with delivering home health services across Wyoming. The Federal regulations require a full-time director in the home health area. In some of our service areas that are currently unserved, maybe the number of clients would only support, at least during startup, a half-time director. That makes us unable to meet Medicare requirements to get reimbursed. The services are not developed.

Kemmerer reports a problem with the education requirements for speech therapist. They had a patient who needed long-term outpatient speech therapy, and the therapists who were providing care in the schools did not meet the Federal requirements to provide that care in the hospitals.

Patients like this, whether they require speech therapy or in some cases physical therapy, who need long-term care, either need to relocate or travel long distances in order to get those services.

Another hospital cited a problem with physical therapy aides. They have trained physical therapy aides, but the physical therapy aide can only function under the direct supervision of a physical therapist. With the shortage of physical therapists in Wyoming, this means that the hours and services they can utilize this person is limited.

On a more personal basis, our local ambulance is not staffed for advanced life support. When we transfer patients from the hospitals to a larger facility, we have two choices. We either call in the helicopter, which at times is indicated and at other times is very costly, or we provide advanced life support staff and equipment on the ambulance. When we do that, which is our most common way of transporting patients, the reimbursement is not there. Because the ambulance is not certified as an advanced life support provider, they get paid only basic rates. In order to become certified, they have to have advanced life support services available on a 24-hour basis. The volume of care that they give and the frequency with which they need those services make it not cost-effective to do so. The ambulance, by the way, is an independent provider. It is not offered by the county or the hospital.

We also deliver a wide variety of services to the community. I think I can probably best explain this by listing some of the services that my hospital provides. I would like to caution you that my hospital is not unique to Wyoming. These are only the things I am most familiar with, and I think you will find similar types of programs across Wyoming.

Weston County Hospital is a 28-bed acute and 41-bed long-term care facility. We are an independent county facility. Our nursing home is licensed both for skilled and intermediate care. We also offer swing bed services in the hospital. We offer respite care at the hospital and some beds are available in the nursing home. We have an adult day care center at the nursing home. We are currently working on a small Alzheimer's group, and working on certifying at least one bed for hospice.

Noting a few years ago that in our community there was a lack of congregate meals and meals on wheels or senior meals, we worked with the local senior center to implement a senior meal program. That program is now offered by one of the local restaurants. However, the hospital continues to provide meals at low cost or no cost, both to seniors and our local indigents, especially during the holidays, when the senior meal program is not available.

One interesting thing I did not put in my written testimony, we also offer hygiene services to some of our local indigents who come weekly to the hospital for a bath and do their laundry for them at no cost.

Within our acute care center, we do lifeline, which is an emergency response system that covers Weston County out into the Upton area. We have organized now, for the last 3 years, sponsored and staffed—and I might say voluntarily staffed by hospital personnel, they do not get paid for this—a local health fair. Last year we had over 800 participants in the health fair. In a community of less than 3,000, that's a significant number.

Last year we began prenatal classes. We had to stop a program where we did home or post-hospital visits to our new mothers be-

cause of our nursing shortage. We have organized specialty outreach clinics which bring several medical specialists into the community on a regular basis. In doing so, we have agreements with Rapid City Regional and Wyoming Medical Center in Casper to provide such services as CT scanning, mammography and cardiology consultation to our community. We also provide a variety of educational services to the community. We have done programs such as the "I Can Cope" program for cancer patients, a lot of nutritional counseling, provided training for home health aides as well as training for nursing home aides, and have an affiliation agreement with Rapid City to assist our staff with our own staff development.

Other programs that I know are taking place in Wyoming include a Homemaker/Home Aide program offered at Sheridan. Wyoming Medical Center has developed a Heart Reach program that includes 11 other Wyoming hospitals that provide transportation, consultation, and education on cardiac-related problems to our communities.

I think to summarize, rural hospitals, including frontier hospitals, are faced with a number of problems that really adversely affect our ability to deliver services and threaten, in some cases, our very survival. Federal programs can both impede and enhance the delivery of care.

Thank you for taking the time to listen to me today.

[The prepared testimony of Ms. Ulmer follows:]

Testimony by Evonne Ulmer
before the
Senate Special Committee On Aging
Field Hearing

July 23, 1990

Mr. Chairman, members of the Committee, I am Evonne Ulmer. I am the administrator of Weston County Hospital in Newcastle, Wyoming. I am also serving this year as the chairman of the Wyoming Hospital Association, a member of the Board of Directors of the Wyoming Healthcare Association and as a member of the Executive Committee of the American Hospital Association's Governing Council for Small or Rural Hospitals.

Thank you for this opportunity to testify today and to discuss the related issues of organization and delivery of health and social services in "frontier" America and the federal designations used to describe our area.

Problems with the delivery of services in rural areas do not readily lend themselves to text book solutions and hence not to simple regulatory relief. While there are commonalties among problems, the degree to which any specific regulation becomes a difficulty frequently depends on the resources available, thus you see similar but slightly different aspects of problems across the state.

Many of the problems in rural health care are well known. There is a physician shortage, a nursing shortage, a shortage of laboratory and radiology and physical therapy personnel. The economy in rural areas is declining and the number of poor and elderly is growing. People in rural areas appear to have more health problems than our urban neighbors. Hospitals are in financial distress. As a result they are cutting services or in some cases, closing. These problems are certainly not unique to Wyoming or our frontier neighbors, but are true for rural facilities across the nation. The vastness of our frontier area only brings an added dimension to the problem. Resources our urban counterparts commonly take for granted are difficult to access or non existent.

Federal Programs both enhance and impede service delivery. Positive programs exist at the federal level that assist providers in meeting local needs. Examples include the recent Rural Health Care Transition Grants awarded to two Wyoming Facilities, Federal funding of senior meal programs, funding for the National Health Service Corp, as well as the development of the National Advisory Committee on Rural Health and the Office of Rural Health Policy. There are also a number of federal programs and demonstration projects that show potential for providing assistance. These include the "Health Care for Rural Areas" program and the "Rural Medical Education Demonstration Projects" program.

Unfortunately the reverse is also true. Perhaps the biggest problem for most rural providers is simply the quantity and complexity of the many regulations that we must deal with on a daily basis. Many of the regulations are confusing, cumbersome, time-consuming and costly. This problem is compounded by the limited human resources and expertise available in many rural facilities.

Documentation to adhere to the regulations governing the medicare program, required cost reporting,and the regulations from the PRO fill one lateral file plus four four-inch binders in my institution. We are expected to know that information and to use it in our daily activities, Penalties for failing to do so may be as simple as lost of revenue or as serious as sanctions and loss of certification.

Occasionally programs are developed, or special provisions are written into rules and regulations, as a protection for certain providers. Rural providers do not always take advantage of provisions such as volume adjustments peyments, sole community provider status, or programs like the Rural Health Clinic Act due to lack of knowledge about the programs and the lack of the technical expertise to

interpret and respond to the regulations. A recent GAO report on rural hospitals cited two instances where hospital administrators spent about $10,000 each for consultants to help them apply for Sole Community Provider Status.

As a personal example,the program that developed the Swing Beds has had a very positive impact on rural providers and communities, however the amount of paperwork necessary to comply with the regulations is time consuming and causes considerable frustration among my staff. Every resident admitted to the swing bed program is evaluated on admission. If it appears that the services required do not meet the required intensity to qualify for medicare reimbursement, the nurse has to choose from one of four different denial letters to have the patient sign explaining the reasons why we think Medicare will not cover the care and that the patient will be responsible for the payment of the bill. If we fail to have the form signed within a certain time period or if we chose the incorrect form, neither the patient or Medicare can be billed. This not only takes the time of a Registered nurse to do the physical evaluation but non-productive time spent explaining these somewhat complicated regulations to families . Completing all the required documentation can take an hour or more of scarce nursing time.

When I hear about the difficulties encountered by programs such as the Montana MAF in obtaining a waiver for medicare payment I think that even the rule makers have difficulties at times. While we recognize that many of our solutions require a new paradigm and not a remodeling of an existing program, the freedom to develop those ideas is stymied by the rigidity with which rules are written in order to assure the quality and efficient delivery of care. Strict adherence to the rules becomes the norm, and in an effort to assure quality, all services are lost.

While the medicare regulations are certainly the most obvious they are by no means the only problems. As Congress seeks to resolve high profile problems such as medical waste on New England shores, the solutions developed are not always applicable to our rural areas and further stress the resources we have available. Hospitals and other providers are required to comply to these regulations despite differences in size of operations or severity of the problem.

In an effort to meet the Hazardous Material regulations we have compiled over thirty pages of policies and procedures. We are currently working on our third draft of a Chemical Hygiene plan for our laboratory. A concept that is easy to understand and to implement becomes complicated and obscure when we try to assure that every aspect of the Federal regulations is addressed in writing. In doing so I fear that the policies become so complex that they no longer make sense to the average worker and the real purpose behind the requirement is lost.

Additional problems occur when there is a lack of consistency among agencies. For example, OSHA's handling of blood & blood born infections differ from the recommendations of the CDC. At times it is difficult for even our larger hospitals to clarify the intent of a regulation, For example the Medical Waste regulations of May 30,1989 leaves unanswered the question of what really constitutes medical waste, making it difficult to develop appropriate policies.

In many cases HCFA could do a better job of impact analysis before proposing regulations. A case in point is the Proposed CLIA regulations. Probably all hospitals will fall into the Level II category. How HCFA will interpret the amount of time the Medical Director and technical supervisor will spend on site is very worrisome to me and other small hospitals, as is the requirement that all work be supervised by either a four year medical Technologist or someone certified by HHS. I understand that the certification program no longer exists. With only one of my three lab personnel meeting this educational requirement I am wondering what I will do when my supervisor wants a vacation or takes a sick day. Compounding these problems are the penalties for failing to meet proficiency requirements. I understand the need to assure accuracy in testing but wonder

if the impact to the community that loses it's only laboratory services has been recognized.

Another such example is the proposed Regulations under OBRA for nursing homes that would limit in-house nurse aide testing and certification to facilities that have not had any deficiencies in their surveys. Under those guidelines none of Wyoming Nursing Homes would qualify.

Regulations that require a certain educational level or degree or specified number of hours of service are another cause of difficulty. The degree varies among providers based on the characteristics of their community but the problem seems to be common in the frontier areas where the local pool of resources is small and the population you serve may not be large enough to warrant recruiting a full time person from outside the area.

Discussions with Wyoming administrators verify that this problem is not limited to my institution.

Douglas reports problems with the requirement that clinics under the rural health clinic act be staffed with at least a half-time Physician Assistant or Nurse Practitioner. Considering the population they serve, this is more time than needed and thus becomes cost prohibitive.

Regulations in Home Health require a full-time director. The volume of services needed especially during the development phase may support only a half-time staff. Existing resources can not meet the needs of an elderly widow living 50 miles from town needing twice a day dressing changes yet the frequency that those instances happen does not justify the expense of a full time nurse.

Kemmerer reports a problem with the education requirements for speech therapists. Therapists from the school programs can not serve patients in their hospital or outpatient department. Residents who may need longterm outpatient therapy must either move, travel long distances, or go without services.

Another Wyoming hospital cites difficulties with the regulations which prevent a Physical Therapy Aide from providing services unless under the direct supervision of the Physical Therapist. This is especially limiting due to the difficulty in recruiting qualified therapists and makes it impossible to fully utilize an adequately trained aide.

Our local ambulance is not staffed or equipped for advance life support. When transfers are needed that require these services the hospital sends our staff and equipment, however because the ambulance is not certified we can not bill medicare for these costs. To become certified the ambulance must maintain 24 hr capability not only for these transfers but for routine runs as well. They lack the volume to support this type of service.

I also welcome the opportunity to discuss the some of the many activities that are taking place in our rural area. Hospitals have responded well in trying to meet the changing needs of their communities. My personal observation is that the kind of services available within rural communities are usually determined by two factors: the nature of the community and the special interests and expertise of the local providers.

The scope of these services range from very simple, low cost ways of meeting limited and very specific needs to a number of more complicated delivery systems. The rural hospital is becoming an umbrella for a growing number of preventive, restorative,rehabilitative and aging services.

Explaining the services available at Weston County Memorial Hospital may be a method of highlighting this fact. Weston County Memorial Hospital is a 28 bed acute care hospital with a co-located 41 bed skilled and intermediate nursing home. The hospital became certified for Swing Beds in the spring of 1985. We also offer respite care at both the hospital and the nursing home as well as an adult day care program in the nursing home. We are currently developing a small alzheimer's unit and an inpatient hospice service.

Noting that congregate meals and meals on wheels programs were absent in our community we worked with the local senior center to implement a Senior meal program. While that

program is now being offered by a local restaurant, we continue to offer meals at reduced or no cost to seniors and local indigents during holidays.
We also offer lifeline, an emergency response system, that is based at the acutecare nurses station.

Within the acute care area we have organized and sponsored a local health fair that has grown to serve over 800 area residents. This past year we have begun prenatal classes but have had to cancel home visits for new mothers due to the nursing shortage.

We have organized speciality outreach clinics which bring several medical specialists into the community on a regular basis and have agreements with both Rapid City Regional and Wyoming Medical Center to provide services such as mobile CT Scanning, mammography, and Cardiology consultation by the use of fax machines. We provide a variety of educational services to the community and have an affiliate agreement with Rapid City to assist with staff education.

Types of programs offered at other facilities are as varied. For example; hospitals in Illinois and Minnesota offer on site "wellness or "fitness" centers. Other rural hospitals have developed alcohol and chemical dependency programs.

While few Wyoming Hospitals have taken advantage of the rural health clinic act. Converse County is currently working on a program that will provide clinic services to Glenrock.

Memorial Hospital of Sheridan developed a "Homemaker/Home Aide Program" to provide housekeeping and non-skilled personal care to seniors and others with restricted daily living activities.

Wyoming Medical Center in cooperation with eleven other Wyoming Hospitals has developed Heart Reach, a coordinated program that involves community education, formal transfer relationships, program development and education that reaches into the rural communities.

Other western states are involved in more structured programs. What comes to mind is the Affordable Rural Coalition for Health or ARCH program and the Northern Montana Health Care Alliance in Montana. The Alliance is a cooperative effort of six hospitals and the health services of two Indian Reservations, whose purpose is to improve health care services by improving cooperation between the hospitals in their area. They are concentrating on four areas: obstetrical risk management, shared services such as Physical Therapy, continuing education, and physician recruitment.

A 53-bed hospital in rural Idaho has helped to provide health insurance to small business employers in hopes of reducing the number of uninsured residents.

Finally, on the question of a reaching a common definition of "frontier". I agree with the Office of Technology Assessment's statement that it is difficult to "quantify rural health problems and to make informed policy decisions without a clear definition of what and where "rural" areas are. I also know that rural is not rural is not rural when we look at the characteristics of our communities and that a perspective that acknowledges the effects of geographical distances as they relate to program implementation has considerable merit. I do not feel, however, that I have the knowledge at this time to recommend one methodology over another.

To summarize, rural hospitals including rural hospitals in frontier areas are faced with a number of problems that adversely effect their ability to deliver services and threaten their very survival. Federal programs both impede and in some cases enhance the ability to provide services. Care must be taken, however, not to look at our frontier problems and the solutions as isolated from the health care system as a whole. The examples I've listed earlier are not problems limited to frontier providers.

I am not insensitive to the problems faced by the regulators as they develop programs that must meet the needs of a diverse population. Thus I understand the use of structure, specific rules, regulations, and educational qualifications as surrogates for quality where outcomes have not been defined.

The issue becomes how does the government achieve two apparently incongruent goals: assuring that services purchased and provided are of acceptable quality and price and still provide the freedom to develop programs that are responsive to local conditions, provide access and enable the establishment of appropriate community-wide systems of care?

Solutions lie in the collective knowledge of federal, state and local providers. We need to assure that flexibility is developed that would allow states to apply for and receive waivers of medicare and medicaid rules to encourage rural systems appropriate to local needs. We need to pay heed to and act on the recommendations of the National Advisory Committee on Rural Health.

Thank you for the opportunity to address issues concerning service delivery in rural and frontier areas. I look forward to working with Congress and others in the public and private sectors to address solutions to rural health care issues.

Senator SIMPSON. Thank you very much, Ms. Ulmer. I am always very impressed by what you do in that very comparatively small community, the county seat, and how creative you are.

Dr. Driggers.

STATEMENT OF DR. DAVID DRIGGERS, M.D., DIRECTOR OF THE NETRONA COUNTY FAMILY PRACTICE, PROGRAM DIRECTOR, UNIVERSITY OF WYOMING FAMILY PRACTICE RESIDENCY PROGRAM

Dr. DRIGGERS. Thank you, Senator Simpson.

I am going to discuss what I view as the challenge for rural health care in the 1990's in Wyoming. The things I will talk about are coming from the perspective of a physician, but the problems are identical to those of the other health care providers here in the State of Wyoming as well as the hospitals.

I think what we have been discussing today so far is that not only is health care becoming more difficult in Wyoming because of its unique stature, but also that health care access in the rural areas in particular is in fact decreasing. One only has to look at the Star Tribune a few weeks ago to see that 35 physicians had left the State for various reasons.

In addition to this, there are several hospitals in the State that are not only facing financial difficulties, but are in fact close to closing. As in the remainder of the Nation, Wyoming residents and rural residents in general are becoming older, with increasing reliance upon Medicare. They are growing poorer, therefore having fewer resources, and in fact are growing fewer in number.

In facing those changes, I think it is important for us to look at some legislative initiatives, and in particular look at the implementation of these initiatives in regard to the impacts, specifically, upon Wyoming.

I would like to pose and then discuss the following question. How can we help the rural areas compete with urban areas for accessible, quality health care? More specifically, what resources do we need to mobilize to make the playing surface level for the rural hospital and the rural health care provider? I would also like to discuss some of my observations concerning recent legislation initiatives.

As far as resources go, it is important to improve access to quality rural health care. I believe there are at least four resource areas we need to address in order to make this possible. These areas are specifically economic, professional, personal, and lastly, technical assistance. I am glad Larry is here today.

The area of improving economic resources is the hardest. Yet in the health care providers' mind, it is the simplest. All the health care provider is asking, along with the hospitals, is to have equal pay for equal services. The rural physician looks at his urban brothers who are making 50 percent more in wages and wonders why, when he performs the same service, he gets less compensation. This is particularly true when he looks north to Canada and realizes that the rural family physicians are paid more than urban family physicians. This is because of the recognition of the isolation

and the difficulties in terms of the local resources. They also, interestingly, place their more experienced family physicians in these rural areas, because they realize the challenges of providing quality health care in those areas.

There is certainly an economy of scale, and we have already alluded to that earlier in previous testimony. There is an economy of scale that works against the small rural areas. For example, if the family physician pays $24,000 a year in malpractice insurance and only delivers 25 or 30 babies per year, he is in essence delivering babies and enduring all the pressures that type of practice entails in order to pay the malpractice insurance premium.

Hospitals face the identical problem in terms of economy of scale. An example could be drawn from the purchase of x-ray machines which are vital, but when a small community only uses these x-ray machines four or five times per day in comparison to the large urban community that may use them 40 or 50 times a day, you can see the problem of economy of scale.

In Casper, we have an outstanding medical community. Unfortunately, we had a cardiologist leave Casper after being able to charge approximately $800 for a coronary arteriogram. He went into an urban area and immediately was reimbursed $1,500 for the identical procedure. Wyoming Medical Center has chosen to be designated as a sole provider, which is an urban designation instead of the rural referral area, which is a rural designation, simply because the reimbursement is greater.

We are indeed competing on an uneven playing field with the urban areas.

In order to provide quality health care in a rural setting, physicians must have specific training which may be different from the urban areas. In family practice across the Nation, there is a growing concern that the curriculum currently mandated by the accrediting bodies is directed more at the urban family physician than the rural family physician. Our family practice residency, in order to maintain its image as a trainer of rural family physicians, has had to absorb not only current curricular requirements for urban areas, but also impose—at the expense of electives—certain curriculum, including complicated obstetrics, advanced cardiac life support, and advanced trauma life support. We have graduated in the 12 or 13 years that the program has been in existence, 71 family physicians. Two-thirds of these practice in towns of less than 15,000 and a third practice in towns of less than 5,000. We are by board exams in the top third of the Nation, but we have no idea in terms of national directive what type of curriculum we should be training these future family physicians. Nor do we have the legislative direction to funding bodies for specific rural family practice residency training programs.

We do believe that no other specialty of medicine can provide the cost-effective health care as a family physician can provide. This is more important in frontier areas.

Certainly the drawing card of rural areas is the quality of life—good schools, clean air, low crime rate. This is balanced by the prospect of being in a town where you are the only, or one of two family physicians. This is affectionately known as "widow makers" among the physicians. There has to be a greater emphasis on qual-

ity of life, which in turn will improve the quality of health care in those areas, and we must look at the fact that certain areas simply cannot support physicians. We must look and explore how we can better utilize physician assistants, nurse practitioners, and the home health service providers. These are areas that are unique to Wyoming, and must be looked at and must be reimbursed appropriately if those services are going to remain in the rural areas.

There are some communities in which no health care provider is feasible, and in those areas there absolutely has to be an outstanding emergency medical health service available.

Envision for a second the process we went through several years ago, which involved Midwest, WY, a town of about 500, where a group of solid citizens looked at their community and were attempting to apply for Federal funds with two major objectives. First, designation of that area as a health manpower shortage area, and second, a rural health clinic. Needless to say, these people need technical assistance to go through the inner workings of HCFA to understand the process. They also need technical assistance in the actual writing of the grant. There is great wonder why, in the fifth largest State in the Union with the sparsity of population—I have looked on the map and there are 5.5 people per square mile, so we ought to be designated a frontier State of the whole, looking at certain statistics—there is only one federally designated rural health clinic and my information says there are 14 health manpower shortage areas. That might be off by one or two, but not by many.

Why have we in Wyoming not been able to obtain these designations? The reasons are certainly diverse. But I believe at the State level we must have a program for technical assistance that is closer than Washington, DC, that would help us weave our way through the bureaucracies, and also establish health care and health care advocacy when we are dealing with certain agencies such as Medicare.

Mr. Chairman, your legislative enactments over the past year have been great as far as the health care providers are concerned. At least we now have the recognition that there are indeed major problems. I think there are some nuances that I would like to take about 3 minutes to address.

First of all, the reimbursement save. Congress in its wisdom recognized that cognitive skills by primary care physicians oftentimes are equal or surpass the technical skills or procedural skills. Through legislation you have sought to raise the reimbursement for the primary care physician and decrease that of the sub-specialist. Unfortunately, the implementation of the legislation has led to the cutting of the sub-specialist faster than the raising of the reimbursement for the primary care physician. There is growing concern that the aggregate Medicare dollar, instead of remaining the same, is actually shrinking. That may allow little, if any, gain, by the primary care physician. This also has an impact on other allied health care providers, as well.

Through the Medicare Physician Payment Reform, it was hoped that rural health care providers would be able to obtain a fair reimbursement. Unfortunately, as part of that bill, there is a geographic practice cost index affectionately known as GPCI that also

includes a cost-of-living adjustment. Based upon our information, it appears that GPCI will perpetuate the higher reimbursement of the urban physicians. This in effect is once again funneling the primary care physician to the urban areas, away from the rural areas.

In its current form, GPCI also implies the cost of practice in urban areas is greater than rural. However, this has not been validated. The American Academy of Family Practice feels that in fact the costs of the rural family physician and other health care providers for certain services as compared to the urban family physician and urban health care providers once again in large measure due to the economy of scale we have mentioned may in fact be greater.

We have already alluded to the fact that small communities need technical assistance in order to obtain the health manpower shortage area designation. This will be particularly important given the 10 percent reimbursement differential written into the current legislation.

There are other programs that exist through the HMSA designation. We worked with one small community this past year where we were hoping to put one of our graduates. Not only would we have him practice as a rural family physician, but because of the health manpower shortage area designation, part of his medical school loan might be repaid. We got down to the 99th hour and were told there were no further funds for that specific program.

As Ms. Ulmer has mentioned, there is grave concern about the laboratory regulations. Most small communities, such as Baggs, Midwest and Medicine Bow have small medical laboratories which provide basic services for their communities. If the laboratory regulations are enacted, one specific example is that the given community, whether it be run by a physician or allied health care practitioner, will no longer be able to do strep throat exams. As you know, strep pharyngitis is an important concern in Wyoming. There is concern that failure to continue to do these screens may allow a resurgence of rheumatic fever to occur. It is extremely important to look at how that legislation adversely affects particularly the small communities of Wyoming.

Lastly, regarding what we call the 125 percent cap on Medicare, as you know, in 1991, there is 125 percent cap on the balance billing for Medicare. Although this was a remedy that was welcomed by the beneficiaries, it once again had a negative impact upon the rural family physician. Although it did actually recognize that there was a problem in the rural areas, some rural family physicians are actually being reimbursed—and I might add some rural hospitals are actually being reimbursed—at 50 percent of the national average for reimbursement.

We are certainly playing on what I call a very uneven field. Until we address the resource areas that have to be mobilized, the personal, economic, technical assistance, as well as reimbursement issues, I believe the people in Wyoming are going to continue to see their health services decrease.

Thank you, Mr. Chairman.

[The prepared statement of Dr. Driggers follows:]

RURAL HEALTH CARE CHALLENGE FOR THE 90'S

David Driggers, M.D.

Introduction

Mr. Chairman, I would like to thank you and your committee for this opportunity to give you some of my observations concerning rural health care, and the direction that it is going. I somehow feel as though I am preaching to the choir, since you already have a great amount of knowledge and understanding of the dilemma facing the rural areas of our state. The problem is that access to health care in rural areas is decreasing. One only has to look at the Casper Star Tribune on the 12th of this month which related that approximately 35 physicians left the state during 1989. In addition to this, there are several hospitals in the state that are not only facing financial difficulties but are in fact close to closing. As in the remainder of the nation, Wyomingites in rural areas in general are growing older with increasing reliance upon Medicare; they are growing poorer, therefore, having fewer resources; and they are fewer in number.

In the face of these changes, well intentioned legislation, and more specifically its implementation, should be scrutinized as to its impact upon health care in rural areas.

I would like to pose and then discuss the following question: "How can we help the rural areas compete with the urban areas for accessible, quality health care?" More specifically, "What resources do we need to mobilize to make the playing surface level for the rural hospital and rural health care provider." I would also like to address my observations concerning recent legislative initiatives.

Resources

I believe that it is important to improve access to quality, rural health care. I believe that there are at least four broad resource areas that need to be addressed in order to make this possible. These are economic, professional, personal, and technical resources.

Economic

The area of improving economic resources is the hardest and yet in the health care providers' mind, the simplest. All that the health care provider who elects to live in a small town is asking from Medicare and Medicaid is equal pay for equal work. The rural physician looks at his urban brothers who are making 50% more in wages and wonders why, when he performs the same service does he get less compensation. This is particularly true when he looks north to Canada and realizes that under the Canadian medical system rural physicians are paid more than urban physicians. This is because of their recognition of the isolation and difficulties in terms of resources that the given location entails. They also place their more experienced family physicians in rural areas because of the diversity of knowledge and experience that is needed to provide quality medical care in that area.

There is certainly an economy of scale that works against small rural areas. For example, rural malpractice rates may be similar to those of the urban physician. However, if a rural family physician must pay $24,000 a year malpractice insurance in order to do obstetrics and only does thirty deliveries per year, he is essentially delivering children with all the stresses that form of practice encompasses just to pay for his malpractice fee. Hospitals and physicians wage the similar battle of economy of scale. An example could be drawn from the purchase of x-ray machines which, although vital, are only used three or four times a day in a small rural setting, as opposed to 30 or 40 times a day in an urban setting. In Casper we have an outstanding medical community. Unfortunately, we had a cardiologist leave Casper after being able to charge $800 in Casper for a coronary arteriogram. In an urban area he charged $1,500 for the identical procedure. Wyoming Medical Center has chosen a sole provider designation which is an urban rather than rural Medicare designation because of the reimbursement scale. We are indeed competing on an unevan playing field with the urban areas.

Professional

In order to provide quality health care in a rural setting, physicians must have specific training which may be different than for urban physicians. In family practice across the nation, there is a growing concern that the curriculum currently mandated by the accrediting bodies is directed more at the urban family physician than the rural family physician. Our family practice residency, in order to maintain its image as a trainer of rural family physicians, has had to absorb not only current curricular requirements but at the expense of elective time impose additional training in such areas as complicated obstetrics, advanced cardiac life support, and advanced trauma life support. Our program has graduated 71 family physicians who, as a group, rank in the upper one-third of the nation. Fully two-thirds practice in towns less than 15,000. One-third practice in towns of less than 5,000. In spite of this, we have no clear picture or definition of what the curriculum for rural family physicians needs to be, nor do we have the legislative direction to the funding bodies for specific rural family practice residency programs. We do believe that no other specialty of medicine can provide the breadth and cost-effectiveness of rural health services as can family practice.

Personal

The obvious drawing card for the rural health care provider is a community that has good schools, clean air, an abundance of outdoor activity, a low crime rate, and in general an excellent environment for family life. This is balanced with the prospect of being in a one or two doctor town which are affectionately known in medical circles as "widow makers." The health care planners can not expect that placing one or maybe two physicians in an isolated community is a long term plan or solution. Greater emphasis must be placed on improving the practitioners life style which includes consideration of increased utilization of other health care providers such as physician assistants and nurse practitioners. In communities where no health care provider is feasible, an excellent emergency medical service is needed.

Technical Assistance

Please envision for a second a town of approximately 500 such as Midwest, Wyoming, where a group of solid, long-term citizens of that community attempt to apply for federal funds with two major objectives. First being designation as a health manpower shortage area and secondly, a rural health clinic. Needless to say, these people need technical assistance to probe the inner depths of H.C.F.A. to understand the process. They also need technical assistance to gather data to support the grant application. There is great wonder why, in the fifth largest state in the Union with its sparsity of population (5.5/square mile), there is only one federally designated rural health clinic and only fourteen health manpower shortage areas. Why haven't we obtained these very appropriate designations? The reasons for this are certainly diverse, but at the state level, a program for technical assistance would improve in large measure the ability of the small communities to understand and weave their way through the bureaucracies of the federal government. It would also establish a health care provider advocate when dealing with Medicare or other agencies.

Legislative Enactments

Mr. Chairman, I would like to, first of all, compliment both you and Congress in your recognition of the problem of rural health care and your attempt to remedy some of the problems through recent legislation. However, I would like to take this opportunity to point out some of the nuances of this legislation and how it may adversely impact Wyoming.

RVRS

Congress, in its wisdom, recognized that cognitive skills by the primary care physician often times has equal if not more value than procedural skills. Through legislation, you have raised the reimbursement for the primary care physician while decreasing that of the sub-specialist. Unfortunately, the implementation of the legislation has led to the cutting of the sub-specialist at a much more rapid rate than the raising of the reimbursement for the primary care physician. In reality, there is growing concern that the aggregate Medicare dollar, instead of remaining the same, is actually shrinking which may allow little, if any gain, by the primary care physician.

Geographic Multiplier

Through the geographic multiplier, it was hoped that the rural health care providers would be able to obtain a greater reimbursement. Unfortunately, as part of that bill, there is also a cost of living clause which, if one uses current information, will in fact raise the reimbursement of urban physicians, possibly as much or more than the actual geographic multiplier. This, in effect, is once again funneling the primary care physician to the urban areas away from rural. It also applies that the cost of practice in urban areas is greater than rural, however, this has not been validated. The American Academy of Family Practice feels that there may in fact be approximately a twenty percent

greater cost to the rural family physician for certain services as compared to the urban family physician, once again in large measure due to the adverse economy of scale.

Health Manpower Shortage Area

We have already alluded to the fact that small communities need technical assistance in order to obtain their health manpower shortage area designation. This is going to be particularly important given the 10 percent reimbursement differential written into current legislation. Other programs exist with H.M.S.A. designations. We recently had the opportunity of working with a small community in Wyoming which had obtained the health manpower shortage area designation. The hope was that one of our graduates would locate there, and as a result, obtain the benefit of medical school loan repayment, which is also part of the program. However, we were told at the last minute that there were no available monies for the loan repayment program.

Laboratory Regulations

Written in recent legislation is a set of guidelines for physician laboratories. Most small communities such as Bagge, Midwest, and Medicine Bow have small medical laboratories which provide basic services within their community. If the laboratory regulations are enacted, one specific example is that the physician will no longer be able to do strep throat screens. As you know, strep pharyngitis and the fears of a possible resurgence in rheumatic fever are important to the people of Wyoming, and strep throat swabs may no longer be available through the small laboratories in communities without a hospital.

125% Cap

The Congress realized that the rural physician, during the implementation of this new legislation, would be at a disadvantage and allowed 125% cap of the maximum allowable charge during 1991. Although this was a remedy that was welcomed, it pointed out the fact that a maximum allowable charge for the rural family physician is lower than that of urban family physicians. It may still allow charges by the rural physician to be lower than in the urban community. Some rural physicians are actually being reimbursed by Medicare at 50 percent of the national average floor.

Closing

The legislative intent that we have discussed was outstanding and will in fact alleviate some of the problems of the rural family physician. What I believe is that the implementation by Medicare of the Congressional mandates should be brought forward with a sensitivity to the rural areas. Until such time as the economic, professional, personal, and technical resources are brought to bear along with the the recognition of the problem of rural health care access, then the health care consumer in the small rural communities of Wyoming will continue to see health care services decrease.

Senator SIMPSON. I thank all of you very much. This is most interesting testimony.

My interest here—I didn't get appointed to the Special Committee on Aging, I sought it. I have some very deep personal observations, with a father who is 93 in November, who has been in a long-term care center in Cody, WY for over 2 years now. Ann's mother is 90, and is also in the Westpark County long-term care center.

I watch their care as best I can, feeling guilty, of course, like all children do. There is a mixture of love and guilt which is very, very real in this situation. There is no way to equate it.

You see another thing, where these people who are very seriously dissembling are being treated by people who are 27 years old, who don't understand a 90-year old person very well, and are not very patient with them, even though they try hard. It is just moons away from their lives and they are paid such an inadequate salary, and they usually have enough turmoil in their own life that they can hardly think of any others.

That's my experience. They have a divorce going with their daughter, or their kid is on pot, and there they are taking care of people all day long who are incontinent and sometimes incapable of comprehending. That's where the rubber hits the road, as I have seen it. That's what created my interest. Then my mother is 90, and she is able to care for herself in her home. That gives her great self-confidence.

My daughter-in-law is a registered nurse. She is now, after raising this lovely grandchild, involved in home health care 2 days a week. Last week she was at the Two Dot Ranch. I said "How are things out at the Two Dot?" That's part of her covered duty. It is so real, and I think that's what impelled me to get into it, just because it is growing.

Then I watched the defeat of catastrophic health care, which was very distressing, because some of the most fortunate people in America did not choose to pay the $800 a year surcharge. Yes, we should have recognized how many had their own insurance plans. That was Congress' error. Yes, we should have enabled those people to opt out. But the issue was the cost to 80 percent of the older people in America. It would have been $4.16 a month, going to $10.60 a month in 1993. That would have covered 80 percent of the seniors in America. The next 15 percent would have had to pay no more than $200 a year more than that, and then as I say, the top 5 percent of the people in America would have had to pay $800 a year, going to $1,500 in the year 1993. It crumbled. I don't know what we are supposed to do when nobody wants to pay. That was just catastrophic. Long-term health care is going to cost 10 times more than catastrophic. If you don't think those aren't vexing issues, then you tell me.

Meanwhile, Jim Roosevelt and his happy band of squirrels keep hammering on our heads all day long. It is not pleasant, and I think very inappropriate. So these are some of the things that impelled me here.

But there is one thing that is very, very real. You talk about the pre-admissions screening and annual resident review program, and

the critically important thing of when we find the person diagnosed with mental illness or developmental disabilities, who can't be accepted into a nursing home that does not provide "active treatment." Well, no nursing home in Wyoming is going to be able to provide that treatment. Then as you say so poignantly, they are going to have to go the training school or the State hospital. To move a person from Newcastle or Cody or Sheridan—a veteran could go into the VA hospital in Sheridan, but that again is renowned for that type of service—you remove them from their communities and their support networks. I think that is very sad.

I hope we can do something and get that message across. I have had that come up in town meetings before. But I know that you, Larry, wanted to discuss a bit more the criteria that are now used to develop these health manpower shortage area designations. Briefly, will you discuss those criteria that are now used, and how they actually discriminate against the frontier State?

Dr. MEULI. The criteria that are used to designate health manpower shortage areas and then are used as criteria to receive National Health Service Corps physicians are as follows: One is the infant mortality rate, second is the percentage of the population with incomes below 200 percent of the poverty level, third is the population to primary care physician ratio, fourth is the percentage of minority population, fifth is the percentage of special populations, which include the homeless, migrant and seasonal farm workers, perinatal problems, persons with AIDS, substance abusers, and elderly persons, sixth is vacancies as a percentage of total budgeted staff, and seventh is the degree of rurality.

When you start talking about the percentage of minority and special populations and when you are talking about the percentage of the population with incomes below 200 percent and infant mortality rates, in those four areas, Wyoming is really at a disadvantage. The reason is that our infant mortality rates are based on Caucasian rates, which are relatively low. So we don't get points for that.

When you include a whole county in a designated area, we don't have enough pockets of poverty population in a county to fulfill that. In the minority populations, only about 5 percent of our total population really fits into the minority category, so we don't have those populations, and we don't have the special populations, drug abusers, those with AIDS and so on. Not that it doesn't occur in Wyoming, and I want to remind you that our AIDS patients are just as sick and die just as rapidly as the ones in New York City, and other urban areas. They are just not recognized and are not considered victims, they just feel like they are having a run of bad luck.

We score minimally on these criteria, therefore, it is very seldom that our frontier States really are designated as health manpower shortage areas. In the whole region, Region 8, there were 44 designated areas. The cutoff point was 20 points or higher. The highest scoring place in Wyoming—Greybull had a score of 19. They didn't even reach the cutoff point, but the regional people felt guilty at not having a designated area in Wyoming, so they picked Greybull.

When you talk about smallness of hospitals, distances between providers, those types of things which really differentiate a frontier

State from a rural State, including weather conditions and so forth, none of those have any points in this designation, so they are not considered.

Senator SIMPSON. Those criteria are obviously nearly impossible to meet. These are the kinds of issues that are being examined in these hearings and in Arkansas and other States that have serious similar problems.

The one that came to my attention most recently was the Federal law which required each State to allocate half of its substance abuse treatment grant to treatment for I.V. drug users—half of it. Then if the State failed to meet that requirement it would lose the entire grant. Wyoming does not have an I.V. problem of any great proportion, but it must still set aside those funds, then victims of alcoholism wait 6 to 8 weeks between visits to the treatment center, which is funded by other moneys in the same grant, because there is not enough money there to pay for another counselor. It reaches absurdity. That is one that was most clearly brought to my attention, and we have spent some time trying to amend legislation to meet these needs.

I might turn to Evonne Ulmer: All of you mentioned credentialing requirements as a problem for nurses aides, lab technicians, and so on. As a health care professional and a superb, creative one, I am certain you don't want to be providing these services unless you are comfortable with the quality of care. How are your noncertified personnel properly trained?

Ms. ULMER. We, like most providers, use a variety of methods. We use a lot of on-the-job training. We also do a lot of formal classroom type training. Our nurses aides, for example, even before the regulations that required certification, had in-house requirements for so many hours worth of training for them.

We use computer assisted training, videos, we belong to HEDS/CHEP, which is a northeast consortium, using VA resources, as well as hospitals in northeast Wyoming, South Dakota, and Montana that do a lot of on-site educational programs. We use a lot of proficiency checklists, where employees have to demonstrate that they are able to do a procedure satisfactorily before they are allowed to do it unsupervised.

So we really use a variety of ways to assure that the care that is done will be done with quality in mind.

Senator SIMPSON. You do a lot of hospital generated activity, a lot of new services that help both your revenues and the community. Is that kind of horizontal integration an option for many hospitals?

Ms. ULMER. I think so. I think in the small rural frontier areas, you are going to see more and more of that. By necessity, hospitals are going to be the health resource for the community, because there is nobody else providing the services a lot of the time. A lot of the services that we provide are not reimbursed. A lot of my staff provide a significant amount of services to the community free of charge. When you are talking about home health and the problem with I.V. therapy, I know that my staff has made home visits to use PCA pumps, which is a pump to deliver a pain medication to hospice type patients. They use the hospital's pump, and they take it home, then we teach the family, then the nurses go in

on their day off, or when they get off their 12-hours shifts, to make sure it is working correctly.

You see a variety of people coming together to meet the needs of the community as best they can.

Senator SIMPSON. One final question. You have organized outreach programs, and outreach clinics, and visiting specialist programs. I am sure those are popular, but are they still faced, and aren't we all in Wyoming faced in the various places where we live with the situation, where people will still bypass the small hospital or care center and head for Rapid City or Billings or Salt Lake or Denver or Scotts Bluff or Idaho Falls for nonemergency care?

Ms. ULMER. Yes, I think that's true. It's a problem that rural hospitals have, rural consumers feel the grass may be greener on the other side of the State line, or that bigger is also better. That's not necessarily true. We work hard to communicate to the community what services we do have available, so they know what is offered in the community. When we are not effective in doing that, when the community lacks confidence in our ability or lacks knowledge of the services available, those consumers that are most able are the ones who will travel, those with health insurance and those that are relatively healthy and can travel easily. It leaves then, the burden on the communities to care for the elderly, the poor and the indigent who don't have those options.

Senator SIMPSON. Dr. Driggers, yours is a critical role. I remember when the State legislature dealt with whether to have a medical school at the University of Wyoming and it was determined not to do so. I think that, as I look upon it, was a good decision, knowing the cost, and watching what is happening in Georgetown and some of the other affiliated schools with large universities where you have to pay faculty members $200,000 up to $275,000 a year to attract them. That's nothing extraordinary, to attract any kind of skilled surgeon.

Then it fell upon you to do the training of a number of the physicians who were practicing in remote regions. What kind of medicine do you have to teach these people, is it a meat and potatoes kind of medicine? What is done there? Would you briefly say how that differs in a State like ours.

Dr. DRIGGERS. I could talk on that for 30 minutes, Mr. Chairman.

Senator SIMPSON. No, you can't. See this right here? [Laughter.]

Dr. DRIGGERS. I alluded to that fact in my testimony. I believe there is indeed a discussion nationwide as to two different types of family practice programs. One is what we have here in Casper, that is a program that is dedicated to training future rural family physicians, a family physician that can address the breadth of what is seen in small communities.

One of our graduates left and is now in practice in Newcastle with Evonne. I like to think that it is indeed a special breed of cat, if I can pull back on my Air Force Academy days. There is a need for a family physician in a small community who is willing to deliver 30 or 40 babies a year, and can do it well, and can recognize a high risk situation and can begin an appropriate transport.

There is a need for a rural family physician who can handle, at least for the first 2 hours, almost any kind of trauma problem in

terms of stabilization, getting an appropriate I.V. started, intubating the patient if necessary, getting the blood going, and calling the nearest trauma center and getting the helicopter there.

There is a need for a family physician who recognizes that indeed rural Wyoming is getting older, that the population has an increased reliance on Medicare, that understands the transition from being independent to semi-independent to being a dependent person, and knowing the resources within the communities that we have all discussed already today, from home health care to what the hospital can provide.

We hope we are training that type of person.

Senator SIMPSON. I think that's what the people and the legislature expect. It would be my hope that the major medical centers in this country can try to cross-train their residents for rural practice, and let them know what is out there. I think many of them would take that option, if they knew the type of practice.

When I was in the legislature, for 13 years in Cheyenne, we tried to almost force those people to stay in Wyoming. You can't do that. It's indentured servitude, I believe is the term for it. You can't force a person to be trained in Wyoming and then stay here for 2 or 3 years for a sum certain. That was difficult.

But I do appreciate your views. One thing I hope will get through, and is leaking through, is that the new Medicare fee schedule is going to try to quantify the relative costs of providing medical care in the frontier regions and the urban regions. We are going to get rid of this assumption, which came from the Wyoming doctors when Medicare first started that practice costs are lower out in the frontier. As health care officials went around the State and said "What do you charge for an appendectomy?" The doctor would say to this Government person "Seventy-five bucks."

The nurse would say "Doc, I've been telling you to charge $150." That was where the divergence came. They started the statistics right then, and never stopped. Somehow there was a difference. And there is no difference, and it has been so tough to cut through that.

There is no difference in practice costs, equipment costs, malpractice costs, specialty services. That has to be said again and again. The rural area doctors inadvertently brought that upon themselves, as Medicare statisticians went around to do their work in the 1960's. It stuck, and we are still stuck with it.

I thank you all very much. It has been very helpful and good testimony.

Evonne, does Mary Wing still contact you daily?

Ms. ULMER. Not daily, but frequently.

Senator SIMPSON. There's a lady up in Newcastle who is the mother of Charles Wing, who played ball with me at the University of Wyoming. When I have town meetings, Mary would say "Alan, you need some shaping up." She is something, isn't she?

Ms. ULMER. Yes, she is.

Senator SIMPSON. Amazing, marvelous, lovely, vigorous lady.

If we can go now to our final panel on social and community service. We will hear from Steve Zimmerman, Administrator of the Division of Community Programs, Wyoming Division of Community Services of Health and Human Services. He is responsible for all

the federally assisted programs in the area of substance abuse, mental health, developmental disabilities, and more. He manages contracts with over 150 providers in various program areas to assure services are delivered in all of Wyoming's 23 counties, and meet Federal program standards.

He has a B.A. from Metropolitan State College in Denver, an M.A. in Special Education and Rehabilitation Counseling from the University of Northern Colorado in Greeley. Before migrating here, Steve was a vocational rehabilitation counselor in Des Moines.

Then we have Scott Sessions, the Director of the Wyoming Commission on Aging. He is a native of Wyoming. I have known a lot of Sessions's in my time, most of them from somewhere up around Big Horn Basin. Scott has served as the Director of the Wyoming Commission on Aging for the past 10 years.

He is responsible for administering a wide range of social and community service programs funded under the Older Americans Act, including the very popular meals on wheels, the senior centers, senior employment programs, home health, transportation programs. He has a B.S. from Utah State, and prior to assuming his current post, he served as the recreation director at the Idaho State Youth Training Center, and was the director of the recreation department in Powell, in Park County.

Please proceed, gentlemen. All your testimony will appear in the records as if read in full.

STATEMENT OF STEVE ZIMMERMAN, ADMINISTRATOR OF THE DIVISION OF COMMUNITY PROGRAMS, WYOMING DIVISION OF COMMUNITY SERVICES, HEALTH AND HUMAN SERVICES

Mr. ZIMMERMAN. Thank you, Senator Simpson. I appreciate the opportunity to address the Senate Special Committee on Aging. It is a privilege to communicate with you again and other members of the Committee my thoughts on frontier human service delivery in the great State of Wyoming.

Wyoming is a State of immense size, as mentioned earlier, approximately 400 miles east to west and 350 miles north to south. It contains 98,000 square miles. The average population density is five persons per square mile. This frontier status makes delivery of human services difficult if those services are not provided in a carefully planned and integrated and flexible manner.

After 17 years of delivering human services across Wyoming, wearing out at least three vehicles, and spending many days and nights driving before sunrise and after sunset to return home or get to the next stop, in weather than can be pleasant, as it is today, but also weather that can be 30 degrees below zero with ice and blowing snow on roads that if not closed, soon should be, it is etched in my mind the need for service delivery that meets citizens' needs in a well-planned integrated resource pattern. I believe there is a need for integration of Federal, State, and local resources and that this integration should be expected.

Service integration makes Federal auditors wince. It is important that this partnership have flexibility to effectively meet human service needs of citizens. Wyoming citizens mirror citizens of the United States in many respects. However, the density of population

has a profound impact on how services can be provided to those citizens.

In my early days of human service delivery, I lived in Des Moines, IA, a city at that time of approximately 400,000 people. It had many agencies and delivery sources, all of which could be reached by a half-hour drive. Coordination of those services, while difficult, was possible.

I then moved to Wyoming, which held the same number of people in 98,000 square miles versus the former 100 square miles. The impact on how the same services are delivered is immense. In Wyoming, sparse population and immense space requires committed persons to use many resources to meet citizens' needs. It is not practical to have individually bundled services as are often required by Federal initiatives, unless there is sufficient funding attached to deliver the services desired by the Federal planners.

I am painfully aware as an administrator of a division that serves four major service areas—developmental disabilities, mental health, substance abuse, and family violence and sexual assault—that the kind of delivery that must occur in this frontier State is not permitted by the increasingly prescriptive Federal funding requirements.

I began to be aware almost 4 years ago that the day of the block grant was over. While Federal funding may still be called block grant, it is being administered in an extremely categorical and prescriptive manner. Year by year, more and more flexibility that resulted in good service delivery to Wyoming have been eroded. As this is happening less and less can be accomplished with Federal funds.

For the sake of this testimony, the division of the State government that I administer administers the following Federal funding: Victim Assistance, Drug-Free Schools and Communities Grants, Comprehensive Mental Health Planning Grant, Mental Health Homeless Grant, HUD Homeless Grant, Community Services Homeless Grant, Family Violence Prevention and Services, Education of Handicapped Part H and Part B, Community Youth Activity Grant, and Adolescent Mental Health Treatment.

We have some experience with Federal funds. The alcohol, drug, and mental health block grant set-asides and targets have made it impossible to administer portions of the block grant. Worse yet, if a program is developed to administer those moneys, it is virtually unusable by Wyoming citizens.

Examples are, the set-aside for the women's programs in the alcohol and mental health block grant describes in regulations a situation that requires separate staff and programming, including building, to assure that women only are served. In a rural county that has one or two staff members, an area with men, women, and children's needs, the set-aside demand of assignment of staff for women only may be beyond good judgment because of the number of individuals needing that particular service.

While it is perfectly acceptable to have a specialized program to serve the needs of women with a portion of a staff person's time, it may be impossible to defend this activity to Federal auditors.

Another example is the group home loan program which required a set-aside of $100,000 for the purpose of short-term, 2-year

loans to unrelated individuals who wish to begin living together after completing treatment for substance abuse.

The problem is that Wyoming desperately needed additional treatment service for treated substance abusers. However, the intent of Federal legislation is to allow funding of a very narrow approach to such treatment that appears to have worked someplace. That program has been set up as specified by the Federal Government.

To date we have had no requests for group home loan account money. We have complied, but have we served the people?

A third example is the recently passed legislation in the area of mental health that allows mental health homeless funds to be used for that group of seriously mentally ill individuals. However, the Federal regulations will not allow those funds to help with food and shelter, as part of the mental needs of the individual.

In Wyoming, in many small isolated places, there are no shelter programs, and probably none needed on an ongoing basis. So we are prevented from using mental health homeless funds to meet the individual's needs. We have to say "Come back when you have your housing and shelter and we will be able to utilize these homeless mental health moneys for your emotional needs."

The result is that the homeless in this State will see funds return to Washington while they remain in desperate need of help.

Regarding the I.V. drug use setaside which you mentioned, Wyoming is not New York or San Francisco. Our citizens have addictions, but not always I.V. in nature.

The problems specifically are set-asides, categorical methods of service delivery, prescriptive delivery that does not take into account this State's demography. As an administrator, I do not mind being held accountable for the outcome of programs that the Congress wishes to fund. However, to prescribe the method by which that is done I believe lacks understanding and judgment.

Even in urban situations it may be difficult to follow the categorical or set-aside approach. But in this frontier State, with the population density that I have mentioned, it is impossible and results in waste, frustration or worse yet, returning desperately needed funding appropriated because we cannot deliver services in the specific way the funders or their staffs have envisioned.

I believe the solution is in accountability. I believe you must have accountability to spend Federal funding. But I also believe that this responsibility did not need to be attached to the procedures and processes in such detail that they cannot work in Niobrara County or Washakie County or Carbon County.

If you want to have appropriate staffing, indicate what you want the outcome to be, that you want women served, or that you want residential facilities for those that are substance abusers or that you want to see homeless mentally ill have their therapeutic needs met. Then allow administrators to decide, in a State like this, how this can best be accomplished. Also send enough money, if you are prescribing it, so that we can accomplish the task.

The ability to apply for waivers is important. However, as I have recently experienced in the alcohol and mental health block grant, often Federal program people scoff at the reasons we say something will not work.

I have one experience I will relate. Almost 9 years ago, Federal auditors rode with me between Cheyenne and Casper on a snowy, cold, windblown, winter day with white outs, to attend a program review the next day. First of all, that reviewer has never returned to Wyoming. Second, there was a greater understanding of distances and difficulties with delivery.

For those who scoff at our inability to prescriptively provide programs, they need to be in Wyoming for sufficient time to either provide the assistance and show us how it might be done or understand that we are delivering services in a State that requires special sensitivity.

[The prepared statement of Mr. Zimmerman follows:]

July 20, 1990

I appreciate, Senator Simpson, the opportunity to address the senate special committee on aging in this field hearing in Casper, July 23, 1990. It is a privilege to communicate to you and other members of the committee my thoughts on frontier human service delivery in the great state of Wyoming.

Wyoming is a state of immense size, approximately 400 miles east to west and 350 miles north to south, that contains 98,000 square miles. The average population density of Wyoming is five persons per square mile. This frontier status makes delivery of human services difficult if those services are not provided in a carefully planned and integrated and flexible manner.

After 17 years of delivering human services across Wyoming, wearing out at least three vehicles, and spending many days and nights driving before sunrise or after sunset to either return home or get to the next stop in weather that can be pleasant but also weather that can be 30 below zero with ice and snow blowing on roads that if they have not been closed will soon be, have etched in my mind the need for service delivery that meets citizens' needs, is well-planned, and integrates the resources available from many sources. I believe that there is a need for integration of federal, state, and local resources and that this integration should be expected. Service integration makes federal auditors wince. It is important that this partnership have the flexibility to effectively meet the human service needs of citizens. Wyoming citizens mirror citizens of the United States in every respect, however, the density of the population has a profound impact on how services can be provided to these citizens. In my early days of human service delivery, I lived in Des Moines, Iowa, a city at that time of approximately 400,000 people. It had many agencies and delivery sources, all of which could be reached within half an hour by vehicle. Coordination of those services while difficult, was possible. I then moved to Wyoming which held the same number of people in 98,000 square miles versus the former 100. The impact on how the same services are delivered is immense. In Wyoming, sparse population and immense space required committed persons who use many resources to meet citizens needs. It is not practical to have individually bundled services as are often required by federal initiatives unless there is sufficient funding attached to deliver the services which are desired by federal planners.

I am painfully aware as an administrator of a Division that serves four major service areas (developmental disabilities, mental health, substance abuse, and family violence/sexual assault) that the kind of delivery that must occur in this frontier state is not permitted by the increasingly prescriptive federal funding requirement. I began to be aware almost four years ago that the day of the block grant is over. While federal funding may still be called a "block grant" it is being administered in an extremely categorical and prescriptive manner. Year by year more and more the flexibility that resulted in good service delivery in Wyoming have been eroded as this is happening less and less can be accomplished with the federal funds.

For the sake of this testimony, The Division of state government for which I am administrator administers the following federal funding: Victim Assistance, Drug Free Schools and Communities Grant, Comprehensive Mental Health Planning Grant, Mental Health Homeless Grant, HUD Homeless Grant, Community Services Homeless Grant, Family Violence Prevention and Services, Education of Handicapped Part H and Part B, Community Youth Activity Grant, and Adolescent Mental Health Treatment. We have "some" experience with federal funds. The alcohol, drug, and mental health block grant set asides and targets have made it impossible to administer portions of the block grant or worse yet, if a program is developed to administer those monies, it is virtually unusable by Wyoming citizens.

Examples: 1) The set aside for the women's program describes in regulations as a situation that requires separate staff and program to assure that women only are served. In a rural county that has one or two staff, an area with men and women and children with needs, the set aside demand of assignment of a staff for women's services only may be beyond good judgment because of the number of individuals needing that particular service. While it is perfectly acceptable to begin a specialized program to serve the needs of women with a portion of a staff person's time, it may be impossible to defend this activity to federal auditors. 2) The group home loan program which required $100,000 of money to be set aside for the purposes of short-term two-year loans to unrelated individuals who wish to begin living together after completing treatment for substance abuse. The problem: Wyoming desperately needs additional residential treatment services for treated substance abusers, however, the intent of the federal legislation is to only allow funding of a very narrow approach to such treatment that appears to have worked "someplace." That program has been set up as specified by the federal government. To date, we have had no requests for the group home loan account money. We have complied but have we served the people? 3) You have recently passed legislation in the area of mental health that allows mental health homeless funds to be used for that group of seriously mentally ill individuals, however, the federal regulations will not allow funds to help with food and shelter as part of the mental health needs of the individual. In Wyoming, in many small isolated places there are no shelter programs on an ongoing basis so we are prevented from using mental health homeless funds to meet individuals needs but rather have to say, "Come back when you have housing and shelter and we will then be able to utilize this homeless mental health money for your emotional needs." The result is that the homeless in this state will see funds returned to Washington while they remain in desperate need of help. 4) IV Drug set aside: Wyoming is not New York or San Francisco but our citizens have addictions also but always IV in nature.

The problems specifically are 1) set asides, 2) categorical methods of service delivery, and 3) prescriptive delivery that does not take into account this state's demographics. As and administrator I do not mind being held accountable for the outcome of programs that the federal congress wishes to fund, however, to prescribe the method with which that is done, I believe, lacks understanding and judgment. Even in urbanized situations it may be difficult to follow the categoric or set aside approach, but in this frontier state with the population density I have mentioned, it is impossible and results in waste and frustration or worse yet returning desperately needed funding appropriated because we cannot the specific delivery system that the funders or their staffs have envisioned.

The solution: I believe in accountability. I believe that you must have accountability to spend federal funding, but I also believe that this responsibility did not need to be attached to the procedures and processes in such detail that they cannot work in Niobrara County or they cannot work in Washakie County or they cannot work in Carbon County. If you want to have appropriate staffing, indicate what you want the outcome to be, that you want women to be served or that you want residential facilities for those that are substance abusers or that you want to see the homeless mentally ill have their therapeutic needs met and allow administrators to decide, in a state like this, how that can best be accomplished and <u>also by the way send enough funding allowing us to accomplish the task</u>.

<u>The ability to apply for waivers is important</u>, however, as I have recently experienced with the alcohol, mental health block grant often federal program people scoff at the reason we say something will not work. I have an experience that I will relate. Almost nine years ago federal auditors rode between Cheyenne and Casper on a snowy, cold, wind blown, winter day with white outs to attend a program review the next day. First of all, that reviewer has <u>never returned</u> to Wyoming and second of all, <u>there was a greater understanding of distances and the difficulties with delivery</u>. For those that scoff at our inability to prescriptively provide the program, they need to be in Wyoming for sufficient time to either provide the assistance and show us how it might be done or understand that we are delivering services in a state that requires special sensitivity.

_____ We need waivers without being demeaned
_____ We need the freedom to determine how to deliver
_____ We need to coordinate federal funds in state and local delivery
_____ Minimum allotments (the true block grant should return)

Senator SIMPSON. Thank you, Steve. That was excellent testimony, clearly presented and hearable.

There really was no schedule for public participation, but I am just going to get a sandwich and eat it on the way to the airport, and we will take time for some public questions. I will be glad to do that on anything, and try to do 20 or 30 minutes of that, if I can, after the official panel is ended. If anyone wants to ask a question, I will certainly try to respond, or more importantly, if you want to present some evidence of what we have seen and heard here this morning, I will try to do some of that. I don't know how much we can get done, but we will try.

Scott, please proceed.

STATEMENT OF E. SCOTT SESSIONS, DIRECTOR, WYOMING COMMISSION ON AGING

Mr. SESSIONS. Senator Simpson, it is a pleasure to take part in this hearing on issues facing the frontier States and some of the implications for restructuring long-term care to meet the growing needs of the rural elderly.

The National Resource Center for Rural Elderly with the University of Missouri at Kansas City indicates that rural American defines consistent definition. However, there are unfortunate constants that characterize rural elders. Older rural people are poorer, less healthy, live in poorer housing, have few options in personal transportation, and less availability of transit services. They have significantly more limited access to health professionals as well as community based programs and services than do their suburban and urban counterparts.

The list of deficiencies and inequities can be quite stunning to those unfamiliar with the very real circumstances of many rural elderly. It is often argued that being old and living in rural America is a form of "double jeopardy" where the individual is put at risk by the changes of advancing age and the circumstances of rural residence.

Indeed, if other factors such as low income status or being a member of a minority group or a Native American tribe are added to the argument, there is a case for "triple" or "quadruple" jeopardy.

There are several interrelated themes that form the basic foundation of the rural challenge. One is the lack of a rural human service infrastructure. Given a small pool of economically viable individuals and units of government, private providers—nonprofit and for-profit—tend not to congregate in the economically depressed rural regions, but rather in those areas—urban, suburban, or rural retirement enclave—that can support them.

In some rural regions a once-existent infrastructure of council of governments and community action agencies has shriveled dramatically or fallen away altogether. The multipurpose senior center and State and local governments are thus often forced to use sparse funds to build a service infrastructure such as transit services, before they can even provide the initial components of service.

Where such an infrastructure does exist, there is generally not a large pool of providers to bid on the provisions of these services. Thus, it is not common to see competitiveness acting as a brake on costs, and given this relative lack of contractors, there are few viable alternatives when a contractor is not meeting service expectations.

Finally, existing service infrastructures tend to be concentrated in the largest town or population center in the more populated counties of the planning and service area. Those elders living outside of that service center often do not have adequate access to services, even though such assistance exists within their county.

There is also a lack of a trained labor pool that is a part of this challenge, the lack of a well-trained and/or experienced labor pool from which the senior center can draw upon for precious human resources. Rural providers are all too familiar with the drain of trained personnel from rural regions.

Ironically, where trained and experienced individuals are available, the pay scales of many rural elderly service providers is generally so poor and the prospects of upward mobility within the organization or agency so slim that retention of skilled people is almost as difficult a proposition as recruitment.

Providers of rural elder services are faced with a current generation of their service consuming population, especially those 85 and over. It has been found that there are attitudes, values, and beliefs that must be taken into account before services can successfully be provided. One of the fundamental elements of this attitude is expressed as "If you don't have it, and you can't make it, then you don't need it."

Elders in many parts of the country retain a traditional sense of individual independence, coupled with an occasionally fierce suspicion of government at any level, that prevents them from utilizing those services which they badly need.

Another rural challenge involves lack of adequate Government funding. Political rhetoric concerning not throwing money at social problems to the contrary, adequate funding is a fundamental prerequisite for the provision of programs and services for rural elders. Whether it is Federal, State, or local funds, it is simply impossible to run most services in a decent, acceptable manner if they must scrape for every penny to sustain themselves. Time and energy need to be expended on Federal and State level political action and coalition building.

There is a lack of rural-sensitive Federal and State regulations. Once Government funds are secured, there is an ironic twist. Various Federal and State regulations that accompany monetary assistance often receive poor marks for perceived insensitivity to the attitudes, values, and beliefs of rural older persons, as well as for the ignorance of how programs and services operate in rural environments.

This is generally the result of well-intended officials giving various urban values, practices, and procedures the virtual force of law without an understanding of the unintended rural consequence. While no one would be so foolish as to call for the provision of Government funds without appropriate safeguards to insure their proper and intended utilization, it can be argued that such funding

regulations should reflect rural realities, not urban stereotypes of country life.

In the National Survey of Rural Aging Services Delivery: Problems and Initiatives, presented at the 1988 annual meeting of the Gerontological Society of America, it is indicated that the most frequently mentioned need in rural areas was for transportation. Transportation is seen as pivotal for access to most types of services, including respite and day care, nutrition programs, social programs, shopping, medical care, and other health-related services.

Another major area reported in the survey is the need for community based services for frail elderly and their families. Again, transportation sets the context for this issue.

Many respondents indicated that service delivery to the homebound is a problem, including a lack of local, trained paraprofessional providers which involve social services supports rather than the usual medical model approach.

Wyoming differs very little from its neighbors in the Rocky Mountain regions of the United States. It boasts wide-open spaces, clear skies, and beauty beyond description. It lays claim to some of the finest fishing and hunting, and is home to two magnificent national parks, Teton and Yellowstone.

In many ways, Wyoming is the best kept secret of the United States, remaining hidden from the minds and eyes of most Americans. However, those who call it home are faced continuously with the challenges presented by its geography and predominantly energy and agriculture-based economy.

With only 483,000 people residing within its 98,000 square miles, Wyoming is the epitome of the word rural. In fact there are times when the words frontier and isolated rural are used as descriptors. Isolated rural is defined as less than six persons per square mile. Rural in Wyoming means traveling miles without seeing another vehicle, inhabitant, or community. It means driving long distances for shopping, meetings, medical services, and being isolated, especially during the long winter months when ground blizzards and subzero temperatures can make travel a deadly affair.

For many Wyoming residents, rurality is simply a matter of perspective. A county seat the size of Rawlins in Carbon County, approximately 8,000 people, can be a thriving metropolis for an isolated rancher who lives 50 miles away and gets to town once a month, if then.

Because of these geographic realities, as well as a less than favorable economic picture for the State of Wyoming, Wyoming is on the bust end of an energy boom and bust cycle, and because of a shortage of professionals in the fields of social work and nursing, the phrase "profoundly rural" has been adopted by those who provide social, health, and medical services, as a more appropriate descriptor of the majority of the State's population.

Developing programs and providing services that are locality relevant, flexible, and adaptive has become a necessity. Trying to find what would work and best serve the long-term care needs of the elderly in Wyoming who made up approximately 13 percent of the total population in 1988, is the impetus behind the effort of the Commission on Aging to strengthen statewide collaborative plan-

ning efforts and implementing specific improvements in the State's long-term care system.

The most notable shortcoming of the long-term care systems in Wyoming is the absence of overall coordination, and the resulting services gaps, due also in part to the profoundly rural nature of the State. Each of the agencies has separate intake processes, assessment requirements, eligibility criteria, staffing qualifications, and services funding resources.

Efforts to improve the coordination of care in any systematic and efficient fashion have been hampered by the somewhat contradictory effects of existing programs that finance long-term care, which tend to encourage the use of nursing homes rather than supporting strategies to keep people living independently at home.

The National Survey of Rural Aging Services Delivery indicates that the primary initiative to address the in-home care needs of the rural elderly is to allow local flexibility and adaptation to modify existing programs or policies requiring special accommodations in the development and delivery of services.

In its bid for a 1990 Administration on Aging Federal discretionary grant, the Commission on Aging proposes to take the lead to restructure the long-term care system in Wyoming. The current fragmented long-term care system needs to be replaced with a streamlined, restructured organizational entity which will be able to conduct short, medium, and long range planning, develop comprehensive policies consistent with planning efforts, carry out policies and procedures, make resources available to carry out the plan, and be held accountable for the outcomes.

Both medical and social models of service delivery must be integrated into the restructured organization. It must incorporate local, built-in flexibility and a cost-sharing mechanism, whereby the client and/or their families is paying for a part or all the cost of the services. The services will be available without regard to income levels, because there are some older persons who may have the resources to pay the full cost of services, but still need case management.

Senator Simpson, at the Federal level, I encourage you to consider the following initiatives, which can lead to concrete, measurable changes within the existing Federal long-term care system, and will generate a more responsive network of services for the most vulnerable rural elderly across the United States.

One, States must be allowed to develop and implement initiatives which give statutory authority to offer a broader range of alternative services without the requirements for Federal waivers—that is, without the Federal regulations that greatly limit their scope.

Two, programs that have demonstrated cost-effectiveness should be allowed to continue on a permanent basis. This should include expanding social support services for informal caregivers taking care of the elderly. Particularly, there is a need for additional funding of Title 3(e) under the Older Americans Act.

Finally, the issues facing the rural elderly regarding long-term care has been left primarily to the States, leading to gaps in services, and inequities across regions. This is even more prevalent in rural areas.

Programs have primarily addressed short-range approaches by adding to the existing fragmented long-term care systems, rather than making fundamental reform in the financing and delivery of services. The challenge is to find ways to develop a delivery system that meets the needs of all dependent people and their families, and that can make the most effective use of the resources available in each community.

I thank you.

[The prepared remarks of Mr. Sessions follow:]

Testimony by
E. Scott Sessions, Director
Wyoming Commission on Aging
presented at the Field Hearing on
Issues Facing A Frontier State in Restructuring Long Term Care
Sponsored by
United States Senator Alan K. Simpson

Casper, Wyoming - July 23, 1990

Senator Simpson, it is a pleasure to take part in this hearing on issues facing the frontier states and some of the implications for restructuring long term care to meet the growing needs of the rural elderly.

FRONTIER STATE

The National Resource Center for Rural Elderly with the University of Missouri - Kansas City, indicates that Rural America defies consistent definition, however, there are unfortunate constants that characterize rural elders. Older rural people are poorer, less healthy, live in poorer housing stock, have few options in personal transportation and less availability of transit services. They has significantly more limited access to health professionals as well as community based programs and services than do their suburban and urban counterparts.

The list of deficiencies and inequities can be quite stunning to those unfamiliar with the very real circumstances of may rural elderly. It is often argued that being old and living in Rural America is a form of "double jeopardy" where the individual is put at risk by the vicissitudes of advancing age and by the circumstances of rural residence. Indeed, if other factors such as low income status or being a member of a minority group or Native American tribe are added to the argument, there is a case for "triple" or even "quadruple" jeopardy.

There are several interrelated themes that form the basic foundation of the rural challenge. The lack of a rural human service infrastructure Given a small pool of economically viable individuals and units of government, private providers (non-profit and profit) tend no to congregate in the economically depressed rural regions but rather in those area - urban, suburban or rural retirement enclave - that can support them. In some rural regions a once existent infrastructure of council of governments and community action agencies has shriveled precipitously or fallen away all together. The multipurpose senior center and state; county/local governments are thus often forced to use sparse funds to build a service infrastructure, such as transit services, before they can even provide the initial components of service.

Where such an infrastructure does exist, there is generally not a large pool of providers to bid on the provision of services. Thus it is not common to see competitiveness acting as a brake on cost and, given this relative lack of contractors, there are few viable alternatives when a contractor is not meeting services expectations. Finally, existing service infrastructures tend to be concentrated in the largest town or population center in the more populated counties of the planning and service area. Those elders living outside of that service center often do not have adequate access to services even though such assistance does exist within their county.

There is a lack of a trained labor pool that is a part of this challenge. The lack of a well-trained and/or experienced labor pool from which the senior center can draw upon for precious human resources. Rural providers are all to familiar with the drain of trained personnel from rural regions. Ironically, where trained and experienced individuals are available the pay scales of many rural elderly service providers is generally so poor and the prospects of upward mobility within the organization or agency so slim, that retention of skilled people is almost as difficult a proposition as recruitment.

Providers of rural elder services are faced with a current generation of their service consuming population, especially those 85 and over, that often has attitudes, values and beliefs that must be taken into account before services can be successfully provided. One of the fundamental elements of this attitude is expressed as, "If you don't have it and you can't make it, you don't need it." Elders in may parts of the country retain a traditional sense of individual independence coupled with an occasionally fierce suspicion of government, at any level, that prevents them from utilizing those services which they badly need.

Another rural challenge involves lack of adequate government funding. Political rhetoric concerning not "throwing money" at social problems to the contrary, adequate funding is a fundamental prerequisite for the provision of programs and services for rural elders. Whether it is federal, state, or local funds, it is simply impossible to run most services in a decent, acceptable manner if they must scrape for every penny to sustain themselves. Time and energy needs to be expended on federal and state level political action and coalition building.

There is a lack of rural-sensitive federal and state regulations. Once government funds are secured, there is an ironic twist. Various federal and state regulations that accompany monetary assistance often receive poor marks for perceived insensitivity to the attitudes, values and beliefs of rural older persons as well as for their ignorance of how programs and services operate in rural environments. This is generally the result of well intended officials giving various urban values, practices and procedures the virtual force of law without an understanding of the unintended rural consequence. While no one would be so foolish as to call for the provision of government funds without appropriate safeguards to insure their proper and intended utilization, it can be argued that such funding regulations should reflect rural realities and not urban stereotypes of country life.

In the National Survey of Rural Aging Services Delivery: Problems and Initiatives, presented at the 1988 Annual Meeting of the Gerontological Society of America, it indicates that the most frequently mentioned need in rural areas was for transportation. Transportation is seen as pivotal for access to most types of services, including respite and day care, nutrition programs, social programs, shopping, medical care and other health related services.

Unmet medical needs were reported by a large number of respondents. Three intertwined issues affect medical needs. First, respondents noted difficulty in obtaining transportation to medical services, both because of the distances and the travel time involved. Second, they reported that medical services were increasingly unavailable in rural ares. Hospitals are closing, and there are

fewer rural physicians. This trend compounds transportation problems for both routine and emergency care. Distances and travel time discourage the use of routine health care leading to medical emergencies and health care crises that could have been prevented. Third, respondents indicated that many rural people could not afford medical services, even when they are available.

Another major area reported in the Survey is the need for community-based, services for frail elderly and their families, including a variety of in-home services and day care. Again, transportation sets the context for this issue: many respondents indicated that service delivery to the home-bound was a problem, due to a lack of local, trained paraprofessional providers which involve social services supports rather than the usual medical model approach.

Wyoming Frontier

Wyoming differs very little from its neighbors in the Rocky Mountain region of the United States. It boasts wide-open spaces, clear skies, and beauty beyond description; lays claim to some of the finest fishing and hunting; and, is home to two magnificent national parks, Teton and Yellowstone. In many ways, Wyoming is the best-kept secret of the United States, remaining hidden from the eyes and minds of most Americans. However, those who call it "home" are faced continuously with the challenges presented by its geography and predominantly energy and agricultural-based economy.

With only 475,000 people residing within its 97,914 square miles, Wyoming is the epitome of the word "rural;" in fact there are times when the words "frontier" and "isolated rural are used as descriptors. "Isolated rural" is defined as less than 6 persons per square mile. Rural in Wyoming means traveling miles without seeing another vehicle, inhabitant, or community; driving long distances for shopping, meetings, and medical services; and being isolated, especially during the long winter months when ground blizzards and sub-zero temperatures can make travel a deadly affair. For many Wyoming residents, rurality is simply a matter of perspective; a county seat the size of Rawlins in Carbon County (approximately 8,000 people) can be a "thriving metropolis" for an isolated rancher who lives 50 miles away and gets to town but once a month, if then.

Because of these geographic realities as well as a less-than-favorable economic picture for the state - Wyoming is on the bust end of an energy boom-bust cycle - and because of a shortage of professionals in the fields of social work and nursing (State of Wyoming, Department of Labor, 1989), the phrase "profoundly rural" has been adopted by those who provide social, health, and medical services as a more appropriate descriptor of the majority of the state's population. Developing programs and providing services that are "locality relevant," flexible, and adaptive has become a necessity. Trying to find what would work and best serve the long term care needs of the elderly in Wyoming, who made up approximately 13% of the total population in 1988, is the impetus behind the Commission on Aging's effort to strengthen statewide, collaborative planning efforts in implementing specific improvements in the state's long term care system.

Studies on Long Term Care Issues in Wyoming

Enrolled Act No.87 of the 1987 State Legislature charged the Department of Health and Social Services to conduct a comprehensive study on the availability and financing of long term health care for the elderly in Wyoming. The Department of Health and Social Services, in cooperation with the members of the State Legislature, Department of Insurance and the Commission on Aging, established a task force to study and develop a written report on the long term care needs of the elderly.

The Task Force was made up of representatives from government, the private sector and providers of human service. In its report, "The Wyoming Long Term Health Care Report", published in November 1987, one of the major recommendations was to develop a multifaceted system of long term care, based on series of policy decision points:

(1) Whether to deliberately undertake comprehensive system reform;
(2) The appropriate mix of institutional and community-based care;
(3) Who will be served;
(4) How the eligibility determinations will be used to help people get into the system or to restrict their entry;
(5) Quality assurance mechanisms - building on the strengths of what already exists;
(6) What is the cost in the context of "need" verses fiscal capacity. (p. 12).

In 1989, the Western Research Corporation in conjunction with the Division of Health and Medical Services of the Department of Health and Social Services completed the second comprehensive study for the state of Wyoming entitled, "LONG TERM CARE ECONOMIC EFFECTS OF ALTERNATIVES TO NURSING HOME CARE." This policy analysis for the state Health Care Data Authority was disseminated to the State Legislature to assist its members in developing options for improving the system of long term care in Wyoming. The recommendations from this study were consistent with the one conducted by the Task Force in 1987 of which the substantial recommendations included:

(1) To add a coordinated long term care data collection and retrieval system; and,
(2) To have the State Legislature declare a moratorium on the building of new nursing home beds.
(3) To develop a comprehensive model long term care program which builds on the strengths of the existing service delivery systems and expands the alternatives for in-home care as a primary choice over nursing home care, in Wyoming. (pp. 2-3).

Programs in the Wyoming LTC System

The most noticeable shortcoming of the long term care systems in Wyoming is the absence of overall coordination, and the resulting services gaps, due also in part to the profoundly rural nature of the state. There are five key agencies (programs) involved in long term care services in Wyoming: Commission on Aging, Public Health Nursing, Division of Public Assistance and Social Services, Medicaid, and the Board of Charities and Reform (Institutions). Each of the agencies has separate intake processes, assessment requirements, eligibility criteria, staffing qualifications and services funding resources.

State Institutions Providing Long Term Care

There are five state institutions which provide long term care services for the elderly in Wyoming.

(1) State Hospital for the mentally ill;
(2) State Training School for the developmentally disabled;
(3) Pioneer Home - residential care;
(4) Veterans' Home - intermediate and skilled nursing home care; and
(5) Retirement Center - intermediate and skilled nursing home care.

Medicaid

Wyoming is one of the few states in the country that does not currently have a waiver for Home and Community Based Services through the federal Medicaid program. In 1990, the Division of Health and Medical Services will submit a model waiver for review and approval by the Health Care Financing Administration (HCFA). The existing Medicaid services in the state are authorized through enabling legislation (W.S. 42-4-101 et. seq.). Recommendations for the services come from federal requirements for mandated services and through various state agencies and consumer advocates for the optional services.

The Home Health program under Medicaid was expanded and certain criteria eliminated in July 1989 in an effort to enable individuals to be served in their homes. The expansion included coverage of durable medical equipment such as hospital beds and wheelchairs and medical supplies such as gauze, bandages and diapers. Home health services are available when prescribed by a physician and provided under a plan of care developed and executed by a certified home health agency. [There are only twenty-seven (27) certified home health agencies in Wyoming, of which Public Health agencies represent eighteen (18)]. Cost caps are set in place when the care plan is estimated to be over $1,200 per month. Pharmaceutical services are available when prescribed by a physician and presently are not limited.

Adult Services - Division of Public Assistance and Social Services

Individuals who are eligible for Medicaid are also eligible to receive in-home services provided by the Division of Public Assistance and Social Services (D-PASS). The federal programs include low income energy assistance, chore services, adult foster care, and medical transportation. The state funded homemaker program for the elderly, and adult protective services are also administered by D-PASS in Wyoming. Primary eligibility criteria for older persons to receive services through D-PASS is based on income or the need for protective services. Services under each program are either provided through the state agency or purchased within the community. The number of service units is capped based on the resources available to each county.

Home Health Services and Adult Health Maintenance

Public Health Nursing Services provides in-home health care through two programs: Home Health Services and Adult Health Maintenance. Home Health Services include skilled (acute) nursing care, physical therapy and occupational therapy services, medical social services, home health aides and medical supplies when there is a need for one of the skilled services. The federal Medicare program defines the skilled services that rehabilitate individuals towards their highest level of functioning. When the individual has reached that level then they are considered stable/chronic and no longer eligible for Medicare paid benefits. This leaves some individuals still needing services - without them.

Adult Health Maintenance is for the more chronic care needs of older persons without the resources to pay for them, and is extremely limited to due to the Public Health Nursing services capacity to provide services within each county.

Community-Based, In-Home Services

The Wyoming Commission on Aging, the designated state unit on aging, developed a rural, social model in-home care program in 1985 through contracting with private nonprofit multipurpose senior centers and hospital provider across the state. The major focus of the program is the clients themselves and the services they need to help them maintain their independence, living in their own homes or apartments. The services available include: case management, homemaker, home health aide, adult day care, respite care and hospice care.

The program provides for a case manager in each county to help older persons and his or her family determine what types of services they need and at what time they need them during the day and week. A comprehensive client assessment is completed by the case manager, the client and family members. Then, jointly they decide what will work best for the client. The case manager is responsible to contact the various service providers to broker services and work with the client, family, and direct service care providers to develop a care plan. Each individual situation is evaluated as to the number of hours and duration of services required to meet the older person/couple's need.

Each county program, through the Board of Directors of the designated private-non-profit senior center or hospital provider, decides which services will be made available within the community. This flexibility allows the limited resources to fill the gaps in the community and complement, NOT DUPLICATE, services already available either through a informal support system or other formal care providers. Cost caps are set by each county to best meet the needs of the older persons residing in each community.

The direct services provided through this in-home services program are funded through cost-sharing in which the client is billed each month for the services received, the balance of the cost is shared through local and state funds. A sliding fee scale is used to determine the cost to the client. Since 1985, the clients or their families have paid up to one-third of the total cost of the program on a statewide basis. The cost for the services is discussed during the care planning with the client and his or her family. Most clients feel strongly about paying their fair share for the services that they receive, because they realize that without these services they would be paying for nursing home care. If it is determined that the client cannot afford these services, they will be provided, at no cost. The funding for the Community-Based, In-Home Services program consists of 52% state general funds; 28% client contributions; 16% local funds; and 4% federal funds from Title III-D of the Older Americans Act.

The Commission on Aging has also instituted a quality assurance program, in 1988, to assure that the in-home services project is doing what it was designed to do. Through a 1988 Federal Discretionary Grant (QUALITY ASSURANCE - FOR RURAL IN-HOME CARE No. 90AH0327/01) from the Administration on Aging, the quality assurance program has been strengthened and evaluated. Utilizing the quality assurance assessment instrument, the Commission review team completes quarterly on-site assessments with each county project. The team meets with the senior center project director, the case manager, and a random sample of clients

to determine the quality and progress of the program. The clients candidly share, with the team, their concerns and satisfaction regarding the services they are receiving through the community-based, in-home services program. This is a valuable report which helps solve problems and determine if the program is meeting the goal of assisting older persons in their activities of daily living and staying in their own homes.

Targeting Minorities and Low Income Older Persons Who Require In-Home Care

The Commission on Aging has developed a in-home care client data base from which the information on individual assessments and care plans have been collected. From the information in the data base, in fiscal year 1989, through the Community-Based In-Home Services Program 30% of the 'at-risk' older population provided services were determined to be low income. Case Managers use the Division of Public Assistance and Social Services income levels as a guideline for determining this status. Two percent (2%) of the 'at-risk' population classified as minorities were served during the program year. Wyoming has a very small number of minorities within the state. For the total population over the age of 60 the percent of minorities is estimated to be between 3-5%, from information from the U.S. Census Bureau and the Department of Administration and Fiscal Control - Division of Research and Statistics. This small number does not lessen the responsibility of the Commission to target services for the low income and minority elderly.

The Commission is currently working with the AoA funded National Resource Center on Minority Aging Populations in San Diego, California and other minority organizations to develop methods to increase the participation of minority elderly in all of the programs administered by the Commission on Aging, including long term care services. Dr. E. Percil Stanford, Director of the National Resource Center on Minority Aging Populations will be presenting a workshop on this issue in August 1990 at the Central States Coalition on Aging Conference in Cheyenne, Wyoming.

RESTRUCTURING LONG TERM CARE FOR A FRONTIER STATE

Restructuring the current organization, financing, and delivery of long-term care is one of the more serious challenges facing our society. Every day millions of older Americans face the prospect of impoverishment and endure a physical and emotional struggle to provide or obtain assistance with basic needs or make the decision to go into a nursing home prematurely. Long term care consists primarily of people caring for others. As the focus of care has shifted away from the institutional setting, most long term care is provided by family and friends. State agencies and local programs are taking the initiative to develop and expand community-based, long term care systems.

Our current system of long term care is often fragmented and confusing. It has not encouraged the identification of appropriate services. Efforts to improve the coordination of care in any systematic and efficient fashion have been hampered by the somewhat contradictory effects of existing programs that finance long term care, which tend to encourage the use of nursing homes rather than to support strategies to keep people living independently at home.

The number of elderly persons is increasing, and they are living longer. Thus, unless there is substantial improvement in disease prevention or in curing chronic disabilities, a growing number of people are likely to be functionally dependent on others. With or without change in the current structure and delivery of long-term care, the cost of this care is bound to increase. The challenge is to find ways to develop a delivery system that meets the needs of all dependent people and their families and that can make the most effective use of the resources available in each community.

The National Survey of Rural Aging Services Delivery, indicates that the primary initiative to address the in-home care needs of the rural elderly is to allow local flexibility and adaptation to modify existing programs or policies requiring special accommodations in the development and delivery of services .

Speaking as a representative from the Wyoming Commission on Aging, I encourage you to consider the following initiatives which can lead to concrete and measurable changes within the existing long term care systems, and will generate a more responsive network of services for the most vulnerable, rural elderly across the United States.

1) States must develop and implement initiatives which give statutory authority to offer a broader range of alternative services without the requirements for federal waivers, that is, without the federal regulations that greatly limit their scope.

2) Programs that have demonstrated cost-effectiveness should be allowed to continue on a permanent basis. This should include expanding social support services for informal caregivers taking care of the elderly.

3) Statewide, collaborative planning efforts involving the all of the agencies involved in providing in-home care must be established to reach concrete and measurable changes within the existing long term care system which reflect a more responsive network of services.

We need to build on the strengths of the existing programs including informal support systems and utilize technical assistance, expertise and information from the AoA supported National Aging Resource Centers on Long Term Care.

In its bid for a 1990 Administration on Aging Federal Discretionary grant, the Commission on Aging proposes to take the lead to restructure the long term care system in Wyoming. This includes:

1) the designation a single point of entry into the long term care system in each county, in which pre-admission screening will initiate a decision matrix regarding the alternatives for the older individual/couple within their home community. The agency designated will have responsibility for completing a state approved, unified comprehensive assessment of the individual/couple's situation with the client(s) and/or family members. The information documented in the client assessment will provide the necessary background for any and all agencies providing long term care services within the community to use in determining the need, type and duration of services. Criterion will be established to designate

the single point of entry and may include, but will not be limited to a public health office, a senior center or other appropriate agency.

2) the integration of state funded homemaker services into either Public Health Nursing Services or the Community-Based, In-Home Services Program through the Commission on Aging. A training and certification program will be instituted for the homemakers working under this program in Wyoming.

3) the provision of training and technical assistance throughout the restructuring process, in order to upgrade skills and provide the rationale and necessary information to those involved in the long term care system in Wyoming.

4) the establishment of a transition team from the state agencies to assist each county with local planning and implementation of the single point of entry and the integration of the homemaker program. The transition team will provide on-site assistance in developing time-lines, addressing barriers and building on the strengths of the local community.

5) the provision for quality assurance measures within the restructured long term care system which builds on the efforts of the Commission's previous work and the strengths of the quality assurance mechanisms already in place through all of the state agencies providing long term care in Wyoming.

6) an evaluation of the process and outcomes of the improvements (changes) throughout the restructuring process.

7) the dissemination of the results and products of this project throughout the duration of the project emphasizing replication of the restructured long term care system for rural areas across the country.

The current fragmented long term care system will be replaced with a streamlined, restructured organizational entity which will be able to:

(1) conduct short, medium and long range planning;
(2) develop comprehensive policies consistent with the planning efforts;
(3) carry out policies and procedures;
(4) make resources available to carry out the plan; and
(5) be held accountable for outcomes.

Both medical and social models of services will be integrated into the restructured organization which incorporate local, built-in flexibility and a cost-sharing mechanism whereby the client and/or their families is paying for a part or all of the cost of the services. The services will be available without regard to income levels, because there are some older persons who may have the resources to pay the full cost of services, that still need case management.

In conclusion, the issues facing the rural elderly regarding long term care has been left primarily to the states, leading to gaps in services and inequities across regions. This is even more prevalent in rural areas. Programs have primarily addressed short-range approaches by adding to the existing fragmented long term care systems rather than making fundamental reform in the financing and delivery of services. The challenge is to find ways to develop a delivery system that meets the needs of all dependent people and their families and that can make the most effective use of the resources available in each community.

Prepared by
Margaret A. Auker, Deputy Director
Wyoming Commission on Aging

Senator SIMPSON. I thank you very much, Scott.

Steve, you have covered this well. I noticed that Leslie, in the margin of your remarks has noted that your point in a nutshell was, in her words, "If you are going to be prescriptive then give us all the funds we need to do all the silly things you require. Otherwise, let us do what we know best how to do with the money you do give us, and back off."

Mr. ZIMMERMAN. You have an excellent staff member.

Senator SIMPSON. I thought I would give credit there. At this point, I should thank Leslie Tucker for the arrangements and the testimony and the witnesses, a fine series of panels and splendid witnesses.

Another thing about your remarks, you describe Wyoming beautifully. We heard about a number of health care programs that use these special designations. We see them—HMSA's and MUA's and all sorts of things—to acknowledge population differences.

Are there similar designations used in the social service programs, would they be feasible? Do we need a new glossary there?

Mr. ZIMMERMAN. Senator Simpson, I would suggest that we don't need any more words. I think what we need is an emphasis, as I indicated, on integration and flexibility and trust. One of the things I find as an administrator that often happens because we are in a rural region that is foreign to many of the people we talk to who are administrators in Washington, DC, there is a quick mistrust of what we are doing when we ask for flexibility. It almost sounds to me as if the reaction on the other end of the phone that flexibility means we are trying to cheat.

I think what we need is certainly less words and maybe an introduction of trust. I think frontier and profoundly rural are the words we use in human service delivery, but I would gladly adopt any dictionary word as long as it describes what we are talking about, and had the parameters of flexibility and integration and trust.

Senator SIMPSON. I think that's true, and I think we can get that message across to our region first. We have good, sensitive regional personnel. It surprises me, and I know it is hazardous to say this, but it works. When you get to these situations where you are received with absolute frustration and boneheadedness, just send a letter to me which sets it all out very carefully saying "Dear Al, this is what is happening right now under section so and so, and we think it's absurd." I will just crank up a letter and send it right to the top, to the Secretary, saying "This is a constituent, and this situation seems kind of absurd, and I would like a response."

They rocket right back down to the region. But people don't want us to do that sometimes. They will say that they don't want to injure the relationship they have with this other person, and as if we can do it in some other way. I don't know any other way to get it to dawn on them.

Mr. ZIMMERMAN. Senator Simpson, one of the things that has happened in the last 6 or 7 years is that there has been a tremendous cutback, as we all know, in the amount of Federal travel that Region 8 and other officials from Denver have had. They have used

that as an excuse, I believe, to isolate themselves from this State and other rural frontier States, so that they become more urbanized by the day. They know less of what it is like to deliver services in the rural area.

The example I used in my testimony is a real one. Once that person, who happened to be from Washington, DC, rode on an ice-covered road, he never approached us in the same way he had before. There is a need for a reality check on some of these officials. The fact that they are in Denver does not mean that is in the Rocky Mountain West, necessarily. If you don't leave the Denver metropolitan area, you are urban.

Senator SIMPSON. That's very true.

Scott, let me ask you this. For a case management system in a frontier area, you just don't have a lot of models to draw on, do you? You are really among the first. You have given us point by point material in your testimony, you are winging it, in some sense, aren't you, as to what you have to do in this case management system? You must find a fair way to handle people who have money, people who don't have money, who still need followup, and still need management.

What is the most essential element in a program like that for success, as you see it?

Mr. SESSIONS. I have always maintained that case management is the one thing that would determine the success or failure of the program. But yes, we do have a sliding pay scale, and we do have people that provide full pay for the services they receive. The case managers are such an integral part of the entire program. They go out, and in our rural State, they know these people.

We have a 17-page client assessment form. It is rather time-consuming to go through that. They go out there, they know the people, and they can fill in a lot of the questions that are on there. Not only do they do that, but they come back for a followup assessment. It is more on a personal basis.

Let me give you one example. Over in Sundance, you know how rural Sundance is, a case manager over there was going out and taking care of this rancher, way out in the sticks. This was really the only person the rancher would see for at least a week. The rancher got sick, and could not do his chores. I guarantee you, the case manager even did the chores for this fellow.

The people—the people that are out in those rural areas—look forward to seeing these people. They count on them. I don't know if you have seen the film we developed for promoting the community-based in-home services program. Judge Guthrie was one of the people that we used in that. They just tell such a good story. It gets down to the people level. It is important for them. It is a lifesaver for them.

Senator SIMPSON. We have these long-term care programs, we have these names, we have continuing care retirement communities and adult day care and long-term care insurance—those things are there. But they are not always available, and as you say, it is an intimate State. I have lived here all my life, and it is an extraordinary thing you are doing, because if there is one word to summarize all of it, it is caring. That's what you're doing.

You are innovative and creative, and trying to get along on the budget that is given, and trying to get through the bureaucracy. It is impressive, and you are thoughtful, but it is caring, gently dealing with those less fortunate, some of those pioneers that we will celebrate in this centennial year. Many of them are about the age of the State of Wyoming. And boy, some of them are ornery. They know that that person in the courthouse is the guy they saw and they let him or her come. But they won't let anybody else come. That's Wyoming, too.

This has been very impressive, and it is important for the Congress to hear from people in each State, those who administer the programs and provide the services, enable the access, and many of you here traveled a long way, our observers and guests. I wish I could have heard from you all, because what we are doing here is seeing a hardy Wyoming people.

But the older one gets, the less hardy one becomes. The spirit is willing, but the flesh is weak. That's very true. I really appreciate it. I don't want to delay the witnesses any further, but I am going to stick around for a while and hear from anyone that might want to ask or present something. I certainly don't expect those of you who have come so far to stick around. Anybody can take off.

I do want to thank you all, and I will step down there and do that. If you have any questions, we will get to them.

Harold down there caught me yesterday and said "Simpson, is there room to speak at that thing?" I said "For you, I'll make some."

There is some testimony you wish to have included in the record. I thank you. Rose Miller, who does great work for the seniors in Cody, WY, I know.

Harold, did you want to give me a question? You don't have to do it publicly.

Mr. JOSENDAHL. I will be very brief. My name is Harold Josendahl. I am a member of the Commission on Aging and have had a chance to observe some of these home health care programs at work. I think the point that has been made this morning is very well taken, that your committee needs to consider, and that is that these categorical descriptions simply do not fit in this frontier area of Wyoming.

But I wanted to point out another thing, too. Every time you change something, the aspect we see on the Commission and in the local senior centers, and I am sure in the local public health agencies, every time you add some of those things, the reporting requirements become a monster. We have to hire more and more people that are simply shuffling paper, and I am sure that on the Federal end, you have somebody to read the paper. It becomes a very costly thing that does not help the people that need the services.

Thank you.

Senator SIMPSON. Thank you very much. That's very important. Anyone else?

Ms. HOOVER. Senator Simpson, I am Evalyn Hoover, Project Director at the Glenrock Senior Center. I have written testimony,[1]

[1] See appendix, item 6, p. 217.

but I would like to reiterate some of Scott's remarks, one about the in-home based services.

As I see it, from working in the program for almost 10 years, regardless of what those individual programs are, we have got to stabilize the funding at that local senior center. We are the focal point, and if we not there, I don't know how we are going to administer those programs very effectively. That's what I would ask on all levels. Our counties and towns try to help us, but when we asked to come up with creative funding, we can only do so much on that level. We certainly all need to work together, with that flexibility and trust.

Thank you.

Senator SIMPSON. Thank you. The Older Americans Act is usually very, very heavily supported in the Congress. I do understand that, and I appreciate having this testimony.

Mr. HOUSTON. Senator Simpson, my name is Mike Houston, and I am the Director of the Central Army Counseling Center in Casper as well as President of the State Mental Health Center Directors Association. I met with you and some of your State people last October. I would like to thank you for your assistance on that, and I hope you will continue to plead the charge to try to get some of the more—for lack of a better word—inflammatory aspects of the alcohol and drug mental health block grant out.

I would like to inquire as to what the status is regarding some of the amendments you had successfully introduced last year, that I understand were taken back out by the House?

Senator SIMPSON. Well, how about that? Leslie just handed me a note that on Friday Congressman Waxman tried to strip the amendment out of there. I was with the President in Cheyenne, and that's what happened. You leave town, and the rats get after you.

My legislative assistant, Mike Tongour, was in it because Leslie was gone, too—she was here preparing for the hearing—and they negotiated a compromise, apparently. We will have the waiver for 2 years, and see how it goes. So far, they have not said no to that, and I will be back tonight. Tomorrow I will talk to Henry Waxman, and we will put that on the phone log.

But I think we can at least get that much.

Mr. HOUSTON. Thank you for your efforts.

Senator SIMPSON. I admire anyone who works in the field of alcohol and drug abuse, and I thank you.

Mr. HOUSTON. We can submit letters to your office that will be included in the hearing record of today?

Senator SIMPSON. Yes, indeed. I will hold that record open for—Leslie, was there anything from the Chairman or the staff as to how long the record would be held open on this hearing?

Ten days. That will be helpful. Thank you very much, and I appreciate that.

Anything else? Yes, Tom?

Mr. TOM. Did you say that you were not on this Committee for the Aging?

Senator SIMPSON. I am on the Senate Committee on Aging, which is a—I can't recall how many members there are—but it is a committee with a sizable budget. It is called the Special Committee on

Aging. It is chaired by Senator Pryor of Arkansas. The ranking member is Senator Heinz of Pennsylvania. It has a huge budget of staff, but for the first time, since Senator Pryor has become Chairman, they are directing their efforts toward rural and urban issues.

They do not have the ability—and this is a strange, weird thing—it is the only committee in the Senate that does not have the ability to generate a piece of legislation and report it. Aging-related legislation is generated through the Labor and Human Resources Committee, which is headed up by Ted Kennedy and Orrin Hatch. Senator Hatch often carries the ball, rather than Senator Heinz. We don't have the ability to "craft" a bill. We do it through other committees.

Yes, I've been on it now for over 2 years.

Mr. TOM. That's why it's called a special committee?

Senator SIMPSON. It is called the Senate Special Committee on Aging. I think that is probably the reason, that it does not have the ability to actually report on a specific bill. We have hearings, that's what we do. When we have the notch baby issue, which is those who were born between 1917 and 1922, we have a hearing on that. When we have urban versus rural health care, we have a hearing on that. We are not an investigative committee, we have hearings and field hearings to determine the problems.

That's the purpose of the special committee.

Mr. TOM. I guess what I want to know is what is going to happen to this testimony when you get back to Washington. Will those other guys read it?

Senator SIMPSON. Yes, because finally it is prevalent throughout the country. And with David Pryor, who comes from Arkansas, there is a sensitivity there that was not there before. Senator Melcher was the former chairman, but his staff got vigorously into things with the EEOC and what they were doing. It was almost an extraordinary expenditure of time and effort on the EEOC, and those of us who were on the committee said we ought to stop. We thought we should get on with other things. Dave Pryor does get on with other things.

The testimony will go to the committee, to the senior staff, our very able senior staff lady. She has told us she will be gathering this up. Members of the committee will be having these hearings this year, and they will put all this material together, and we will then make a recommendation to a committee with the ability to craft the legislation.

Thank you.

Ms. SCHNABEL. Senator Simpson, I am Shar Schnabel, Project Coordinator for the Wyoming AIDS Education and Training Project, which is a 3-year Government grant. It mandates that we provide education for health professionals in the area of AIDS education.

Our main offices, our regional offices, are in Denver, out of the University of Colorado Health Sciences. I have become acquainted, being a part of this, with the system they have in Colorado and in several other States surrounding, that have a search AHEC system. I am hearing the challenges that Wyoming faces in the rural areas, with aging as well as mental and physical health issues. I am wondering what your thoughts are as to the advisability of having an AHEC system operating in the State of Wyoming?

Senator SIMPSON. I don't know the answer to that. I will be glad to assist, but I am not certain I can speak on that. I am not familiar with AHEC, what did you say it is?

Ms. SCHNABEL. It is Area Health Education Centers. It is a networking program that a lot of the States have to get to the people, rather than expecting them to come to the larger centers of the State.

Senator SIMPSON. And you are asking if Wyoming should be able to accommodate the same kind of thing that Colorado is using in that area?

Ms. SCHNABEL. Yes.

Senator SIMPSON. Are we not funded at all in that area?

Ms. SCHNABEL. No.

Senator SIMPSON. Well, you see, that's the thing. We have tried to put a condition or an amendment into every kind of health bill that at least some percentage of 1 percent of the appropriation shall go to every State in the Union. To other States that may mean nothing, but it may mean $100,000 to Wyoming, and that's enough to do work. So even though the program has not crossed my desk, I can try to get something together. Larry has some comment on that.

Dr. MEULI. AHEC funds are already pretty well taken up. We have just applied for what's called a health and education training kind of grant that is in the same category, the money has become available, and new rules and regulations are being written for that. We have applied for it.

Ms. SCHNABEL. Thank you.

Senator SIMPSON. Thank you for saving me from a fate beyond comprehension.

Is there anything else?

Ms. Pointer. I don't have a question, but I am Sarah Pointer, from Casper, and I want to tell you how much I have appreciated these people that I know give 150 percent. They give a lot of hours, and are never paid by their salary, to help some of these people.

It must be as difficult for you, being from Wyoming, in Washington, to understand the differences as it is to understand how a 25-year-old can take care of your 90-year-old mother. We kind of feel that way about politicians, that they don't know what Wyoming needs out here.

Senator SIMPSON. I understand that. If you represent Wyoming in Washington, it doesn't matter what party you are in, eventually they say you have Potomac Fever, you have forgotten everything, and don't remember anything about the people you know and lived with. I guess that's a hazard of politics. I was raised in this State, lived all 58 years of my life in it, have 20 to 30 town meetings a year, and if I am not sensitive, I can only tell you that I have invested every mental and physical resource I have. If that doesn't cut it, scratch me off.

That's my comment. Thank you all very much, and I appreciate your caring. Boy, it's tough, and it will get tougher, and it will get tougher with long-term health care. That's the one to be on the lookout for. That's $25,000 a person per year. That's what it is, at least that's what the bill was that came to me. Who can afford that? We are fortunate, not to be on any system or any Govern-

ment support system, except when illness comes, and that comes periodically. Then you are on a Medicare bed for a while, and into another bed. It is an unbelievable thing.

But it will cost millions—billions and billions of bucks. I know the feeling out there, why the hell didn't we do something about the savings and loan thing, and all that? I have heard that. And what's a B–2 bomber cost? I know that one. I am just saying that we are trying to be aware of it. It is one of the great social problems of our day.

But I can tell you one thing that will take place. Those who are more fortunate are going to have to put more into the system. I get hell for that. But I can tell you we are going to go to means testing, and we are going to do other unpopular things, because we have no choice—no choice at all.

I think most conscientious, thoughtful people agree that that has to be. If it is not, then those who are affluent and not affluent are going to leave nothing for their grandchildren in the year 2030, because the systems will be in total disarray. I don't think that's what Wyoming people are about, just to say that I've got mine, and my grandkids can search for themselves. I think that's wrong. I can't be a part of it.

This woman waving her arm is the woman I have been living with—married all that time, of course.

Thank you all very much.

[Whereupon, at 12:22 p.m., the committee was adjourned, to reconvene at the call of the Chair.]

APPENDIX

ATTACHMENTS

A. "Resuscitate the NHSC," The New Mexican, July 5, 1990.

B. CHART: Minimum Recommended Health Services, Frontier Task Force, 1986.

C. CHART: Distinguishing Characteristics of Service Setting, Frontier Task Forc, 1986.

D. The National Health Service Corps Revitalization Act of 1990 H.R. 4487, Recommendations to the Subcommittee on Health and Environment, April 23, 1990, by Henrietta Esquibel and Carol Miller

The listing of Attachments to this document follows.

E. Request to Review BHCDA Frontier Health Policy Issues, From Director, DHSD, Region VIII, To Director, DPCS, April 27, 1990.

ATTACHMENTS to The National Health Service Corps Revitalization Act of 1990, H.R. 4487, Recommendations to the Subcommittee on Health and Environment, April 23, 1990, by Henrietta Esquibel and Carol Miller

A. List of states with frontier area

B. Maps
   - Frontier Counties
   - Farming-Dependent Counties
   - Mining-Dependent Counties
   - Federal Lands Counties

C. Primary Care Activities in Frontier Areas - Regional Guidance Memorandum 86-10

D. 9/29/89 correspondence from Harvey Licht, Chairman, Frontier Task Force, National Rural Health Association to William Aspden, Acting Director, Bureau of Health Care Delivery and Assistance regarding proposed HMSA changes.

E. Wykert, Wade D. Medical Underserved Area Formula for Sparsely Populated States, College of Health Sciences, University of Wyoming, through a contract from U.S. Public Health Service Region VIII.

F. Congress of the United States, Office of Technology Assessment, Defining "Rural" Areas: Impact on Health Care Policy and Research, Staff Paper, July 1989.

Miller, Carol, "Physician Training, Distribution, Practice and Retention Issues," OTA Workshop on Health Professions and Frontier Issues and Strategies, February 28, 1989, Bismarck, North Dakota.

34-175 0 - 90 - 4

G. DHHS, BHCDA, "Frontier Community/Migrant Health Centers by State."

H. American Public Health Association, 8601: Frontier and Rural Health: Agenda for Action, Policy Statement, September 1986.

I. Congressional Precedent on Frontier:
Congressional Record - House, November 9, 1987, H9818, Mr. Nelson.
Section 330, Public Health Service Act, Amendment, SECTION 103. REQUIREMENT WITH RESPECT TO FRONTIER AREAS. Lines 9 - 14.

Congressional Record - Senate, letter to Senator Orrin Hatch from Edward D. Martin.

J. Utah Department of Health, Utah Health Indicators by Land Area Status, Expected Years of Life Lost and Working Years of Life Lost.

K. Osberg, Bernard, "Health Status by Place of Residence, South Dakota Department of Health, 1987.

L. Articles about Frontier
Miller, Carol, "NRHA Frontier Task Force Calls for Federal Adoption of Designation for 'Frontier' Areas," Rural Health Care, National Rural Health Association, January/February 1990.

Appelbome, Peter "Some Say Frontier is Still There, and Still Different," New York Times, December 12, 1987.

Tippens, Jerry, "Old Frontier Faces Modern Problems," The Oregonian, January 21, 1988.

Ellson, Gar, "Frontier Areas: Problems for Delivery of Health Care Services," Rural Health Care, National Rural Health Association, September/October 1986.

July 5, 1990

OPINION

THE NEW MEXICAN
The West's Oldest Newspaper
Founded 1849
Robert M. McKinney Editor and Publisher
Billie Blair Associate Editor and Publisher
Harold R. Cousland, Executive Editor
David N. Mitchell, Managing Editor
Santa Fe, N.M., Thursday, July 5, 1990
202 East Marcy St.
Santa Fe, N.M. 87501
P.O. Box 2048

Resuscitate NHSC

Just 100 miles from Santa Fe, there are thousands of people without access to adequate health care. In rural Tierra Amarilla, one understaffed and underfunded clinic serves the entire community.

It's a shocking reality that many people in America's rural areas have no better access to health care than those in the Third World. Nearly 2,000 communities — almost 34 million people — face severe doctor shortages in the United States.

Legislation sponsored by Rep. Bill Richardson to revitalize the National Health Service Corps (NHSC) is now pending in the U.S. House. The Corps has been the federal government's primary means of recruiting physicians to rural and inner city areas suffering from health manpower shortages. The NHSC's mandate is "to improve and maintain the health status of medically underserved populations."

Because of inadequate funding, the Corps has declined from a peak strength of 3,127 participants in 1986 to 123 this year. This means that a growing number of poor communities, such as Tierra Amarilla, no longer have a primary care physician. Residents must travel a long way for health care and are more likely to die from illness or injury. Pregnant women in labor must drive across winding national forest roads, sometimes through snow, to Espanola or Santa Fe to deliver their babies.

The legislation to resuscitate the NHSC is vital to northern New Mexico and to many other poor communities across the nation. In the past, Corps physicians have thrown medical lifelines to deprived areas. Congress needs to act promptly on the Richardson bill so that Corps professionals can provide their full services once again.

MINIMUM RECOMMENDED HEALTH SERVICES

POPULATION/ SERVICE AREA	EMS	PRIMARY CARE	SPECIALTY CARE	HOSPITALIZATION
less than 500	First Responder EMT B-P	Intermittent MLP or MD by appointment Satellite/part-time clinic, EMT supervision via telecommunication and written protocol	Referral	Referral
500–900	EMT B-P First Responder network in outlying areas	Full-time MLP or part-time MD arrangement for emergency coverage and EMT supervision	Referral or periodic arrangement in the community	Referral
900–1500	EMT B-P First Responder network	Full-time MD or MLP, or combination full and part-time group practice, emergency coverage and EMT supervision	Referral or periodic arrangement in the community	Referral and infirmary model
1500–4000+	EMT B-P First Responder network	Small group practice combination of MD and/or MLP, medical specialists (MD/MLP) IM, PED or OB, CNM as determined by community need, emergency coverage and EMT supervision	On-site full-time regularly scheduled clinic within primary care practice, or referral	Small community hospital or infirmary referral

DISTINGUISHING CHARACTERISTICS OF SERVICE SETTINGS

PARAMETER	URBAN	RURAL	FRONTIER
Driving time	less than 30 minutes	30 minutes	60 minutes or severe geographic & climatic conditions especially seasonal
Staffing	Gate Keepers and specialty teams	Generalist, usually a physician with possible assistance from mid-level practitioners	Practitioner teams mid-level practitioners
Population Density	More than 100/ square mile	More than 6 but less than 100/sq mile	Less than 6 per sq m
Scale	Large group practice	Small group practice	Pair solo or intermittent
Hospital	Large, usually 100 or more beds/facility or satellite	Small 25–100 beds may have swing beds	25 beds or less or no hospital
Technology	High level of technology easy access	Medium level of technology easy to moderate access	Low level of technol difficult access
Skill range of provider	Specialist	Generalist with distinctions, specialist consultation	Extreme generalist infrequent specialist consultation
Intensity of practice	High utilization	Moderate utilization	High standb, capac
Social Organization	Individual anonymity, accepts help readily, greater dependency	Personal group relationships, self-reliant, interdependency, accepts help reluctantly	Personal relationshi self-reliant, resists seeking help

The National Health Service Corps Revitalization Act of 1990
H.R. 4487

Recommendations to the Subcommittee on Health and the Environment
April 23, 1990

La Clinica del Pueblo de Rio Arriba
Tierra Amarilla, New Mexico

Henrietta Esquibel, Executive Director
Carol Miller, Assistant to the Director

SUMMARY OF RECOMMENDATIONS

CRITICAL NEED FOR A SPECIAL FRONTIER DESIGNATION

PRIORITY STATUS ON PLACEMENT LISTS (ie HPOL, MPOL, LOAN REPAYMENT) FOR FRONTIER SITES

NO MANDATORY MOVE OF FEDERAL PROVIDERS WHO WANT TO STAY IN FRONTIER AREAS

AUTOMATIC DESIGNATION OF FRONTIER SITES AS "SMALL HEALTH CENTERS" EXEMPT FROM PAYBACK

HIGH PRIORITY FOR FREE-STANDING NATIONAL HEALTH SERVICE CORPS SITES

FRONTIER AREAS

LOCATION
FRONTIER AREAS CONTAIN 45% OF THE LAND AREA OF THE UNITED STATES AND HAVE A PERMANENT POPULATION OF 3 MILLION RESIDENTS.

27 STATES HAVE FRONTIER AREAS, USING 6 OR LESS PER SQUARE MILE. ALASKA 96% FRONTIER, NEVADA 80%, UTAH 55%, IDAHO 44%, MONTANA 41%, NEW MEXICO AND OREGON 27%, NEBRASKA 24%, AND KANSAS 20%.
(Attachment A - States With Frontier Areas.)
(Attachment B - Maps.)

CONGRESSIONAL PRECEDENT
In existing Congressional precedent regarding frontier areas (Sections 330 and 799A, Public Health Service Act) two different definitions have been used. Both of these Sections are administered by the Health Resources and Services Administration (HRSA) although the two programs are in different Bureaus (330 is in BHCDA and 799A is in BHPr). This will create confusion and a single definition must be determined.

Section 330, Community Health Centers, states that the Secretary will give special consideration to frontier areas. BHCDA Regional Program Guidance Memorandum 86-10 (Attachment C) defines a frontier area as generally having 6 or fewer people per square mile.

Section 799A, Interdisciplinary Training for Health Care for Rural Areas, gives a funding priority to applicants that will provide a substantial part of the training in frontier areas. Section 799A uses the more liberal definition of "frontier" - population density of less than 7 individuals per square mile. The funding guidance for this program acknowledges that "frontier areas are believed to afford the most limited access to health care for the populations residing in them."

It is extremely important that a single, clear definition of frontier be developed and utilized in all legislation.

NEED FOR A FRONTIER DESIGNATION
CURRENT CRITERIA FOR DESIGNATION OF HMSAs DISCRIMINATORY

Recognition of this need has existed since at least 1977.

> *Many of these counties - larger in area than a whole multi-county planning area elsewhere - had only one or two doctors but failed to qualify for CHMSA designation since they had only a few thousand people. This raises the question: should there be special criteria for designating CHMSA's in large, sparsely populated medical service areas?*
> *Critical Health Manpower Shortage Areas: Their Impact on Rural Health Planning, Economic Research Service, USDA, Agricultural Economic Report No. 361, March 1977, p. 6.*

DHHS recognized as long ago as 1980 that current HMSA criteria discriminate against sparsely populated rural areas. Although the Department officially committed itself to developing a special criteria for sparsely populated areas in 1980, the criteria have never been developed.

> *A number of comments have been received, particularly in the course of discussions in regional workshops, to the effect that the criteria in the regulation contain many provisions which have made designation easier for inner-city urban areas, as compared to the designation of some low-density rural areas, which are more isolated. ... Therefore a new category of primary care shortage areas is under consideration for rural areas whose ratios of population to number of primary care physicians are below the previous qualifying ratios. This matter will be dealt with in the later Notice of Proposed Rulemaking setting forth various proposed amendments to this final regulation.*
> *"Criteria for Designation of Health Manpower Shortage Areas; Final Rule," DHHS, PHS, Federal Register, Monday, November 17, 1980, p. 75999.*

Contrary to this commitment by DHHS, the August 8, 1989 Federal Register contained proposed rules to change the HMSA designation which would have eliminated as many as one-third of all HMSA's in frontier states. (see Attachment D, Comments of Harvey Licht, Chairman, Frontier Task Force, National Rural Health Association.)

In order to end this geographic discrimination, the Frontier category must become law. We cannot allow another decade of discrimination to occur against people living in 45% of the land area of the United States.

OFFICE OF TECHNOLOGY ASSESSMENT FRONTIER STUDY
The Congressional Office of Technology Assessment held a Workshop on Health Professions and Frontier Issues and Strategies, February 8, 1989 in Bismarck, North Dakota. Three panels of experts presented testimony on the problems of training, distribution, practice and retention issues for physicians, nurses, and other health professionals in frontier areas. A number of recommendations suggested ways to redesign the National Health Service Corps to better serve frontier communities.

The July 1989, OTA Staff Paper Defining "Rural" Areas: Impact on Health Care Policy and Research, proposes methodologies for defining sub-county frontier areas. Sub-county data will provide a more accurate definition than using only county-wide data. This is very important in geographically large counties where one population center will eliminate the entire county - even though communities 100 or more miles away from the population center in that county have no health care.

This paper also states:

> *Recognizing the unique characteristics of frontier areas, DHHS in early 1986 agreed to use different criteria to evaluate Community Health Center (CHC) grantees (and new applicants for CHC support) and National Health Service Corps Sites. (p.38)*

DHHS has not complied with its own internal policy. This is yet another example of why this special designation and priority status must be included in the legislation.

NECESSARY CHANGES IN HR 4487

SECTION 102. Designation of Health Manpower Shortage Areas.

RE: SECTION 334A

(b)(1)

special frontier designation not based on the ratio of population to providers must be included

DHHS frontier policy, BHCDA RPGM 86-10 recognizes the difficulty in defining a frontier area:

> Because of the unique nature of frontier areas and the difficulty in developing eligibility criteria which fit all cases, there will be an opportunity for organizations to justify any unusual circumstances which may qualify them as frontier, for example, geography, exceptional economic conditions, or special health needs. (Attachment C, p. 2)

(b)(2)

indicators of need appropriate to sparsely populated areas must be developed.

(b)(2)(A)

recommend substituting the statement "infant mortality and/or low birth weight"

(Attachment E: describes how indicators like infant mortality (see p. 2) are disciminatory and irrelevant in sparsely populated areas.)

(b)(2)(C)

health status is a very vague criteria that can skew care towards or away from certain communities

ie., if rate of cardivascular disease is used as an indicator of health status, Native American communities will show a lower than average rate; whereas if rate of diabetes is used as an indicator of health status, Native American communities will show the highest rate

SECTION 104. Priorities in Assignment of Corps Personnel.

This only allows the Secretary to set priorities among HMSA's. Many of the communities with the greatest need will not qualify as HMSA's.

Language providing for "priority of frontier areas" is needed in this section.

Governors of states should be allowed to request designation of shortage areas that do not fit within federal guidance. This is already allowed in the designation of Medically Underserved Areas.

SECTION 105. Effective Provision of Services.

RE: SECTION 336.(a)(2) Choice in Assignments

Recommend deletion of this section as unworkable. It will create more problems than it would solve.

The mechanics of implementing the "choice of not less than 3 assignments" appear to be in conflict with the policy of prioritizing assignment to the areas with the greatest need.

The current method of HPOL (High Priority Opportunity List) consists of a list with the same number of providers as there are vacancies. As people and sites begin to match, the number of choices is reduced. Towards the end of the selection process people rush to match with the more desirable sites left. At the very end of the cycle, providers are "force matched" with the remaining vacancies. This system has problems but at least it assures that each of the highest priority sites ends up with a provider.

How does the choice issue impact the need of areas considered undesirable?

Under this choice system, will free-standing sites continue to compete against Community Health Centers? This has caused problems in the past because the Community Health Centers receive federal funding and have been able to offer a higher salary and more benefits to a provider.

Section 301. Establishment of Program of Grants to States.

Section 338H(b)(1) Requirement of Matching Funds
If it is believed that Offices of Rural Health are important to carrying out the mission of the National Health Service Corps, make their funding a permanent part of the appropriation. Many other programs established on a declining funding formula have not been continued when the federal share was discontinued.

In primarily rural states, it may be redundant to have an Office of Rural Health. This office, with very little funding would be responsible for most of the activities in a state. For example, in New Mexico an Office of Rural Health would cover the entire state except for the 3 SMSA's.

Would this program be in addition to existing Cooperative Agreements with states or is it intended to replace the Cooperative Agreement?

ATTACHMENTS

A. List of states with frontier area

B. Maps
   Frontier Counties
   Farming-Dependent Counties
   Mining-Dependent Counties
   Federal Lands Counties

C. Primary Care Activities in Frontier Areas - Regional Guidance Memorandum 86-10

D. 9/29/89 correspondence from Harvey Licht, Chairman, Frontier Task Force, National Rural Health Association to William Aspden, Acting Director, Bureau of Health Care Delivery and Assistance regarding proposed HMSA changes.

E. Wykert, Wade D. Medical Underserved Area Formula for Sparsely Populated States, College of Health Sciences, University of Wyoming, through a contract from U.S. Public Health Service Region VIII.

F. Congress of the United States, Office of Technology Assessment, Defining "Rural" Areas: Impact on Health Care Policy and Research, Staff Paper, July 1989.

   Miller, Carol, "Physician Training, Distribution, Practice and Retention Issues," OTA Workshop on Health Professions and Frontier Issues and Strategies, February 28, 1989, Bismarck, North Dakota.

G. DHHS, BHCDA, "Frontier Community/Migrant Health Centers by State."

H. American Public Health Association, 8601: Frontier and Rural Health: Agenda for Action, Policy Statement, September 1986.

I. Congressional Precedent on Frontier:
   Congressional Record - House, November 9, 1987, H9818, Mr. Neilson.
   Section 330, Public Health Service Act, Amendment, SECTION 103. REQUIREMENT WITH RESPECT TO FRONTIER AREAS. Lines 9 - 14.

   Congressional Record - Senate, letter to Senator Orrin Hatch from Edward D. Martin.

J. Utah Department of Health, Utah Health Indicators by Land Area Status, Expected Years of Life Lost and Working Years of Life Lost.

K. Osberg, Bernard, "Health Status by Place of Residence, South Dakota Department of Health, 1987.

L. Articles about Frontier
   Miller, Carol, "NRHA Frontier Task Force Calls for Federal Adoption of Designation for 'Frontier' Areas," Rural Health Care, National Rural Health Association, January/February 1990.

   Appelbome, Peter "Some Say Frontier is Still There, and Still Different," New York Times, December 12, 1987.

   Tippens, Jerry, "Old Frontier Faces Modern Problems," The Oregonian, January 21, 1988.

   Elison, Gar, "Frontier Areas: Problems for Delivery of Health Care Services," Rural Health Care, National Rural Health Association, September/October 1986.

ATTACHMENT A

STATES WITH FRONTIER AREA(S)

Region I
- Maine
- Vermont

Region II
- New York

Region III
- Virginia

Region IV
- Florida
- Georgia

Region V
- Michigan
- Minnesota

Region VI
- New Mexico
- Oklahoma
- Texas

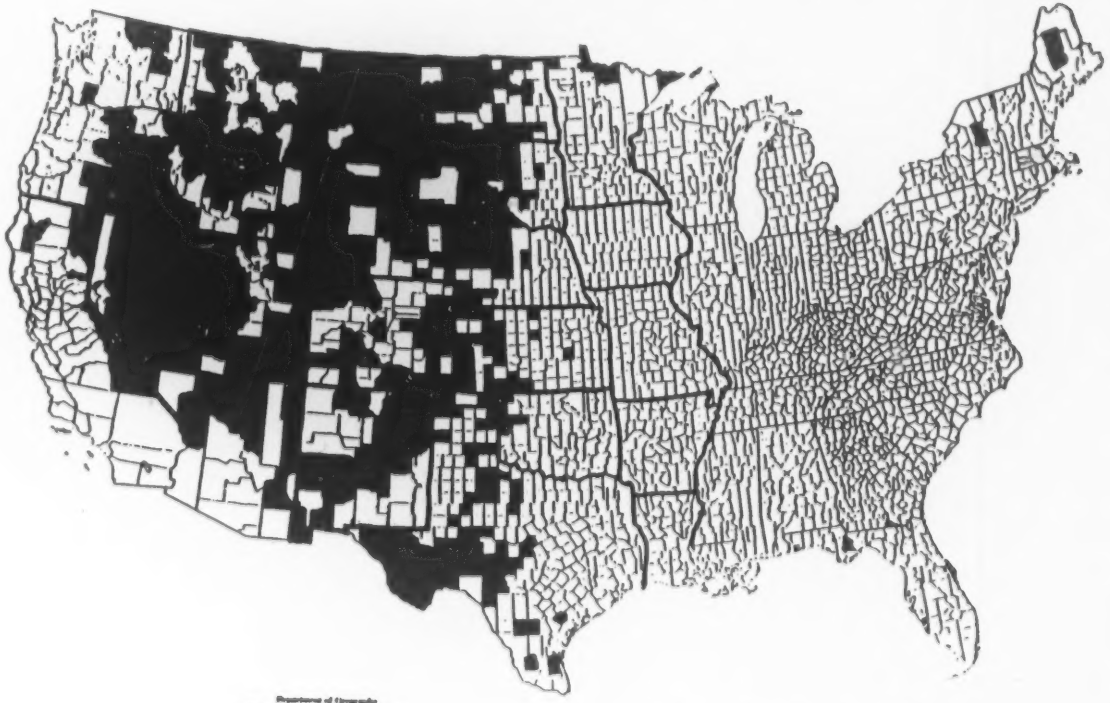
Region VII
- Kansas
- Nebraska

Region VIII
- Colorado
- South Dakota
- North Dakota
- Montana
- Utah
- Wyoming

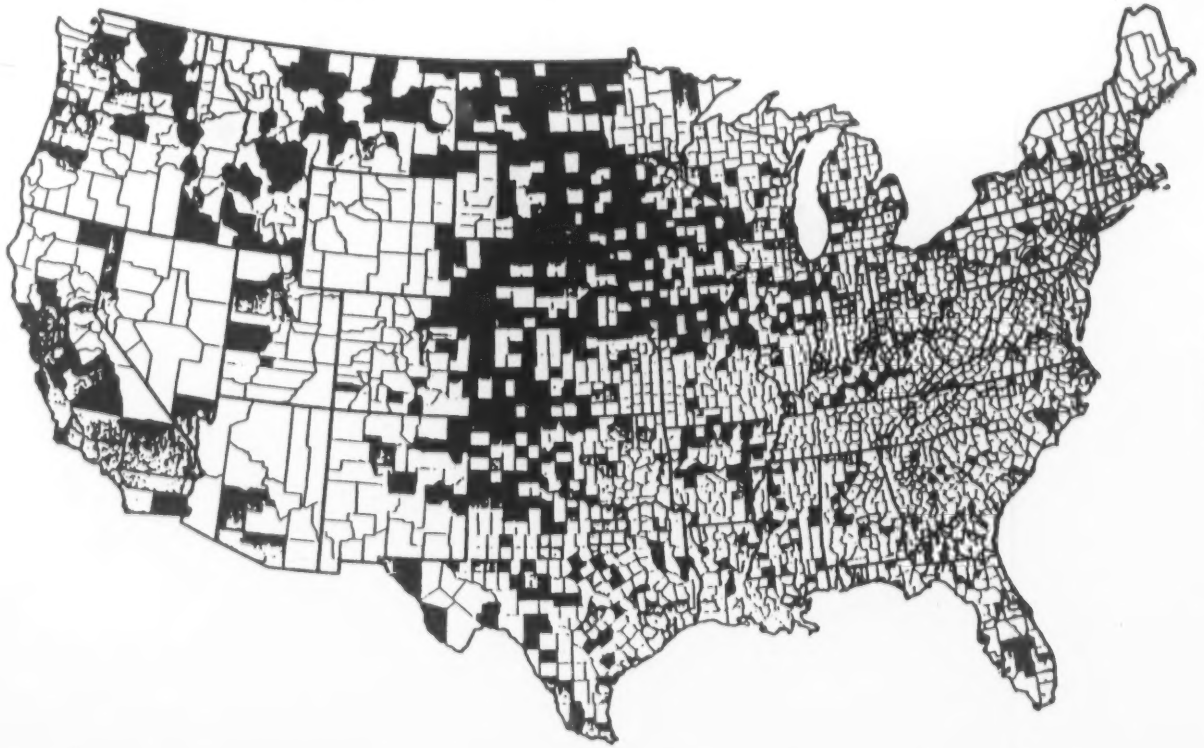
*Region IX
- Arizona
- California
- Nevada

Region X
- Alaska
- Idaho
- Oregon
- Washington

Counties with less than 6 persons per square miles



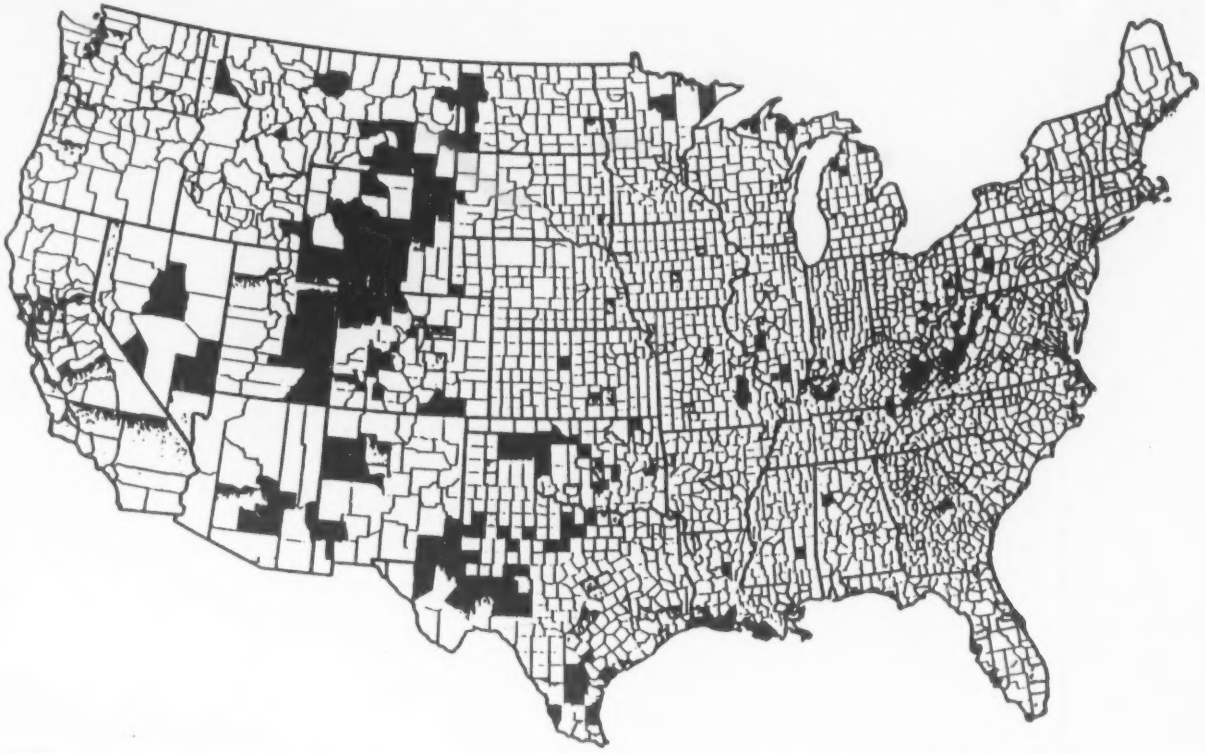
Farming-Dependent Counties



Farming Dependent Counties
Farming contributed a weighted annual average of 20 percent or more to total labor and proprietor income over the five-year period from 1975 to 1979.

Standard Metropolitan Statistical Area

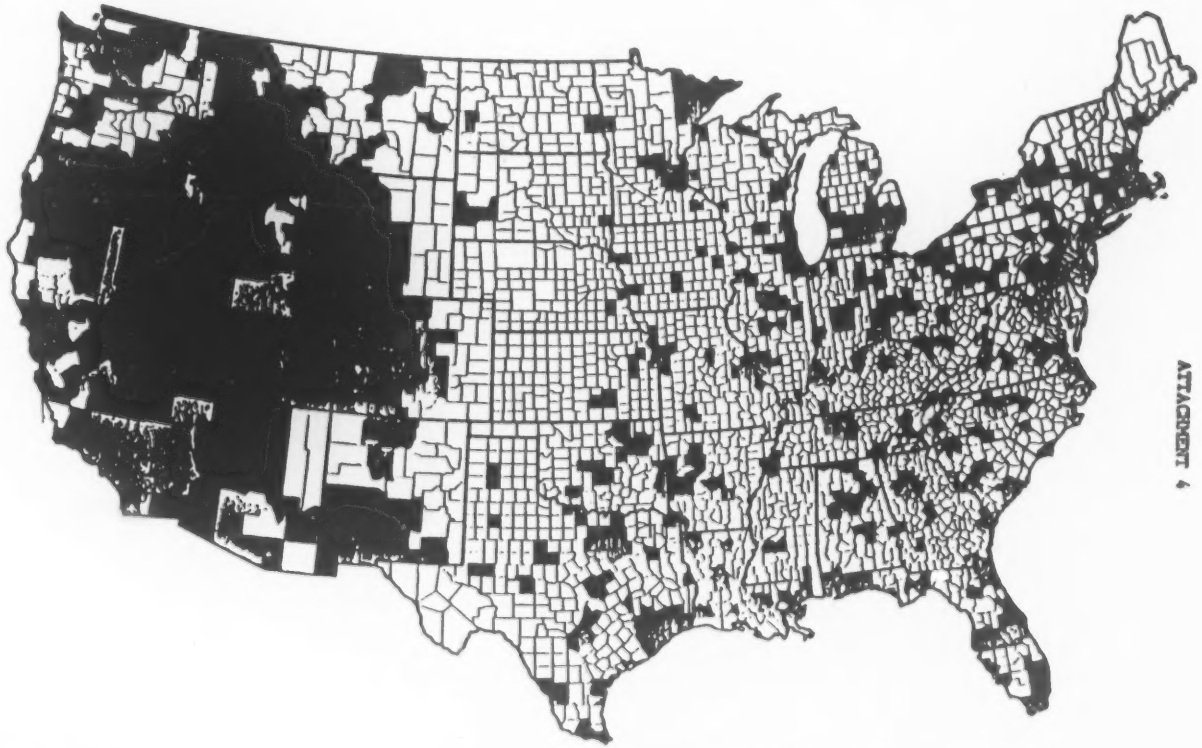
Mining-Dependent Counties



Mining-Dependent Counties
Mining income 20 percent or more of total labor and proprietor income in 1979.

Standard Metropolitan Statistical Area

Federal Lands Counties



Federal Lands Counties
Counties in which Federal land is 33 percent or more of total land area.

Standard Metropolitan Statistical Area

ATTACHMENT 4

ATTACHMENT C

DEPARTMENT OF HEALTH & HUMAN SERVICES — Public Health Service

Memorandum

Date

From Acting Director

Subject Primary Care Activities in Frontier Areas - Regional Guidance Memorandum - 86 - _____

To

Regional Health Administrators, PHS
Regions I-X

In the course of implementing the Rural Strategy of the Bureau of Health Care Delivery and Assistance (BHCDA), it has become apparent that it is difficult to analyze some number of existing grantees and freestanding National Health Service Corps (NHSC) sites, as well as some areas being considered for capacity expansion, using the same criteria as as that used to review rural areas in general. These grantees/sites/areas are generally characterized as having a relatively small population base spread over a considerable geographic area. This distinction is important, because the manner in which services are delivered in these areas which have come to be referred to as "frontier" varies from rural areas having greater population density.

The purpose of this memorandum is to: (1) define frontier areas, (2) establish eligibility criteria for BHCDA support, (3) identify priorities for funding new or continuation applications in frontier areas, and (4) establish a timeline for implementing this policy. It should be noted that any activity related to support for frontier areas must be consistent with the State-based planning efforts ongoing in each State and must involve the participation of the State Health Department and the State Primary Care Association, as well as other appropriate State based agencies, to assure coordination of all available resources.

Definitions:

For the purpose of this guidance, a "frontier" area shall be defined as follows:

- Frontier areas are those areas located throughout the country which are characterized by a small population base (generally 6 persons per square mile or fewer) which is spread over a considerable geographic area.

Eligibility Criteria:

To be eligible for BHCDA primary care support as a "frontier" area, the following criteria must be met:

- Service Area: a rational area in the frontier will have at least 500 residents within a 25-mile radius of the health services delivery site or within the rationally established trade area. Most areas will have between 500-3,000 residents and cover large geographic areas.

- Population Density: the service area will have six or fewer persons per square mile.

- Distance: the service area will be such that the distance from a primary care delivery site within the service area to the next level of care will be more than 45 miles and/or the average travel time more than 60 minutes. When defining the "next level of care", we are referring to a facility with 24-hour emergency care, with 24-hour capability to handle an emergency cesarean section or a patient having a heart attack and some specialty mix to include at a minimum, OB, PED, IM, and anesthesia services.

Because of the unique nature of frontier areas and the difficulty in developing eligibility criteria which fit all cases, there will be an opportunity for organizations to justify any unusual circumstances which may qualify them as frontier, for example, geography, exceptional economic conditions, or special health needs.

Priorities for Funding:

Programs serving or proposing to serve frontier areas must meet the legal and regulatory expectations of all Community Health Centers (CHC) programs; however, because of the special nature of frontier areas, the manner in which these expectations are met may differ. All frontier area programs will be assessed to assure that they address the following:

1. Relative demand for services: the determination of the relative need for services will be based on a consideration of the following:

   - o Economic factors affecting the population's access to health services, with emphasis on percentage below poverty, unemployment, and extent of health insurance coverage.
   - o Available health resources in relation to the size of the area and its population.
   - o Demographic factors affecting the population's need and demand for health services including such factors as seasonal unemployment and/or seasonal variations in population.

2. Systems development: program services need to be provided in a manner appropriate to the needs of the service area. Activities in frontier areas should build upon systems of care which are based in or linked to existing programs whenever possible. An effort should be made to use the strengths of existing CHC's. A priority of resource investment in frontier areas will be to stabilize existing systems of care including, where appropriate, private as well as public entities. An essential component of the systems development must be the ability to arrange for inpatient services at the appropriate level of care. Inclement weather will be considered as a design factor for a programmatic response rather than a reason for a year-round project.

3. Clinical system: frontier sites must, through staff and supporting resources, or through contracts or cooperative agreements with other public or private entities, provide primary health care services that are available, accessible and assure continuity of care. Essential primary health care services must include physicians or mid-level practitioners who provide diagnosis and treatment, preventive health services, and emergency medical services. Primary care in these areas should include the capability to stabilize patients for transport to more advanced levels of care. Provision must be made for lab, x-ray, and pharmacy services, if not available on site.

4. Governance: frontier applicants must be governed by a board that meets all CHC criteria to assure user involvement in the planning, directing, and allocating of resources. Systems of care such as consortia or networks covering large geographic areas must make alternative provisions for community participation.

Timeline for Implementation:

For the remainder of Fiscal Year 1986, the following activities are necessary:

Existing grantees:

- utilizing the criteria of this memorandum, regional offices will identify all existing grantees in frontier areas by May 30, 1986.

- a review of all existing frontier grantees will be completed by regional offices and submitted to Central Office as soon as possible but no later than July 1, 1986. This review will summarize the results of each of the elements under Priorities for Funding described above, as well as the results of the ZBA analysis. A map of the service area and contiguous areas will be included. This map will describe the size of the service area (number of square miles), the population density of the service area, and show the location and highway distance to the next level of care as described in this policy.

- Central Office review of frontier programs will be completed and decisions for continuation funding in sequence with project's anniversary dates will be finalized as soon as possible but no later than August 1, 1986.

New Areas of Activity:

- As part of the Rural Strategy, a limited number of frontier areas may be identified for primary care capacity expansion or consortia development activities. In Fiscal Year 1986, resources will generally be allocated for planning and developmental activities.

- Consistent with the Federal Register notice of February 28, 1986, proposals for new activities in frontier areas will be due in the regional offices by June 1, 1986. Regional offices will submit by July 1, 1986, a 2-3 page summary, for each project, of their review which includes: documentation of eligibility according to the definitions, a description of the proposed activities, a map of the proposed service area as described above, and a determination of the priority for funding using the criteria in

this memorandum. Final decisions on the funding of capacity expansion and consortia development proposals will be agreed to by the regional and Central Offices no later than August 15, 1986.

Any questions regarding this memorandum should directed to Mr. Siegel Young, Chief, Rural Health Branch, DPCS. Mr. Young's telephone number is 443-2220.

Vince L. Hutchins, M.D.

ATTACHMENT D

National Rural Health Association
301 East Armour Blvd., Suite 420, Kansas City, Missouri 64111, Telephone (816) 756-3140
Robert T. Van Hook, Executive Director

September 29, 1989

Mr. William H. Aspden, Jr.
Acting Director,
Bureau of Health Care Delivery and Assistance
Health Resources and Services Administration
Room 7-05, Parklawn Building
5600 Fishers Lane
Rockville, Maryland 20857

Dear Mr. Aspden:

I am writing as Chairman of the Frontier Task Force of the National Rural Health Association (NRHA) to comment on the proposed rules for designation of Health Manpower Shortage Areas (HMSAs) contained in the August 8, 1989 Federal Register. The Task Force is charged with advocating for the needs of frontier areas in the United States. In its review of the proposed regulations, the Task Force has reached the conclusion that their implementation will have a negative impact upon frontier areas. The Task Force urges you to suspend implementation of the new criteria.

The minimum size of shortage criterion contained in the proposed regulations is of major concern to the Task Force. It will lead directly to the de-designation of numerous frontier areas. This de-designation will occur in spite of the assurances included in the background statement for the proposed rules:

> "Most areas designatable under the previous criteria will also be designatable under the revised criteria, although their degree of shortage may change. Some previously designated primary care and dental HMSAs will no longer be designatable as a result of the new minimum size of shortage criterion; however, these will generally be former HMSAs which have very low priorities for placement, and thus were not likely to receive NHSC personnel." (emphasis added)

An assessment of several states which have extensive frontier areas indicates that up to one-third of all HMSAs would lose their designation under the new criterion. The HMSAs affected would be primarily frontier HMSAs. This contradicts the observation made in the Federal Register that most areas previously designated would maintain their designations.

If, as indicated in the regulations, frontier areas losing their designations are to be considered as low priority areas, this would signal a major change in direction for United States Public Health Service (USPHS) policy. Frontier areas are afforded special consideration in the authorizing legislation of some USPHS programs, and have been the focus of special rules; most notably in Policy Memorandum 86-10 of the Bureau of Health Care Delivery and Assistance. Moreover, the preamble to previous HMSA regulations indicated a special commitment to designating frontier HMSAs:

> "A number of comments have been received ... to the effect that the criteria in the regulations contain many provisions which have made designation easier for inner city urban areas, as compared to the designation of low-density rural areas which are more isolated. At the same time, a number of specific cases have arisen regarding rural areas which have less than adequate services, but do not have shortages severe enough to justify designation under these criteria or the criteria for medically underserved areas,... Therefore a new category of primary care shortage areas is under consideration for rural areas whose ratios of population to number of physicians are below the previous qualifying ratios. This matter will be dealt with in the later Notice of Proposed Rulemaking setting forth various amendments to this final regulation." (emphasis added)

This commitment, made in November, 1980, has not yet been fulfilled. The new proposed regulations appear to be an abandonment of the commitment, and more seriously, a reversal of previous policy.

The proposed regulations ignore the importance of the HMSA designation to programs other than the National Health Service Corps (NHSC). This is a narrowing of focus from previous designation regulations which clearly acknowledged the use of HMSA designations by the Rural Health Clinic Services Act. Various state and federal programs use the HMSA designation as part of their eligibility standards. There does not appear to have been an adequate assessment of the impact of the new regulations upon the ability of clinics to participate in these other programs.

The motivation for proposing the minimum size of shortage criterion seems to be related to the administration of the NHSC, and not relevant to the actual need of an area. The proposed regulations state that:

> "... areas which have some practitioners and require less than one additional should not be competing with those areas which have none and/or need at least one additional practitioner."

If this situation is truly a problem, the NHSC could handle it without any need to change the basis of the HMSA designation process. Indeed, currently, NHSC resources are deployed based on criteria in addition to HMSA priority. Seeking to remedy the situation by de-designating areas with measurable need is inappropriate.

The Task Force challenges the notion that frontier areas with a need of less than one additional physician FTE should not be allowed to compete for federal resources. In numerous instances, mid-level practitioners might be assigned under an NHSC program. These assignments would be appropriate, and still leave the area under the threshold for de-designation.

The Task Force believes that if the proposed regulations are implemented, there will be a substantial economic impact upon frontier areas. This is in contrast to the assurance provided in the proposed regulations:

> "The Secretary certifies that this amendment to the regulations does not have a significant economic impact upon on a substantial number of small entities."

The Rural Health Clinic Services Act requires that small clinics be within HMSAs or designated medically underserved areas to be eligible for enhanced reimbursement. Implementation of the proposed regulations will result in a large scale de-designation of frontier areas, and a substantial reduction in Medicaid and Medicare revenues to clinics in these areas. There will be a heavy economic impact upon many clinics, and a threat to the continued existence of service systems in some areas. This impact will be largely restricted to frontier and remote rural areas --areas already hard hit by downturns in extractive industries.

In summary, the Frontier Task Force recommends that the proposed regulations not be implemented. Provisions in the proposed rules will have a deleterious impact upon existing health care systems in frontier areas and upon the ability of frontier areas to establish new systems. The potential exists for a reversal of many of the frontier area health care advances that have been achieved in the last decade.

Sincerely,

Harvey Licht

Harvey Licht, Chairman
NRHA Frontier Task Force

RECEIVED 3/13/87

ATTACHMENT E

MEDICAL UNDERSERVED AREA FORMULA FOR SPARSELY POPULATED STATES

MUA FORMULA FOR SPARSELY POPULATED STATES

MUA
FORMULA
SPARSELY
MEDICAL
UNDERSERVED

WADE D. WYKERT M.S.
OFFICE OF RURAL AND COMMUNITY HEALTH
COLLEGE OF HEALTH SCIENCES
UNIVERSITY OF WYOMING

ABSTRACT

The maldistribution of health care services in some rural states has been exacerbated by the inability to fund a community health center (CHC) with federal 330[1] grant money. This is because in rural communities, the existing criteria may not realistically identify barriers to health care.

The official medically underserved area (MUA) designation can only be achieved when four criteria have been met: 1. ratio of primary care providers to population, 2. infant mortality rate, 3. percentage of families below poverty level, and 4. percentage of population aged 65 years or older.

A fundamental concern with the MUA formula is that some states' remote/rural areas are so unpopulated that when a community of 1,400 residents requires closer or more immediate access to health care it is not possible to document meaningful infant mortality rates. These areas are so small that an infant mortality rate can not be documented because there are so few births. In such communities, infant mortality rate is not as useful a reflection of community health as it may be in larger communities.

Appeals made to regional and federal offices produced no less rigid interpretation of the rules. It was agreed that Western rural states may have a problem in this area and, as such, a contract was entered into between the Office of Rural and Community Health at the University of Wyoming and the Region VIII office in Denver to produce a new MUA formula which would more realisti-

cally address barriers to health care. The formula contained herein is a result of this contract.

[1] 5161-1 Public Health Services Application for Federal Assistance; Community Health Center Funding.

INTRODUCTION TO PROBLEM

Since the inception of the medically underserved area (MUA) concept in 1976, there has been a preponderance of state and federal officials interpreting as absolute standard a formula originally intended to be a flexible guide used to bring help to this country's residents. The outcome has been a formula used so rigidly in interpretation and input as to virtually disqualify the people needing help in rural areas, especially in frontier communities.

The initial idea behind the MUA concept was to allow federal money to aid rural citizens where access to medical care was 15 minutes away or to a hospital more than 30 (Federal Register,1978:1588). Residents of virtually 90 percent of Wyoming's terrain fall into this category. However, as currently defined, the official MUA designation is only achieved when four criteria have been met. These criteria are based on: 1. ratio of primary care providers to population, 2. infant mortality rate, 3. percentages of families below poverty level, and 4. percentage of population aged 65 years or older.

The Report to the Congress of the United States by the Comptroller General, June 15, 1981, criticizes the present interpretation of the regulations requiring all four of the MUA criteria because it is not succeeding in properly identifying areas needing medical attention. The criteria related to infant mortality seems the most problematic for sparsely populated states to achieve. It is failure to meet this criteria which often blocks an MUA designation for a rural area.

The lack of infant deaths per community has excluded a number of otherwise eligible rural communities from MUA designation. Yet this criterion is a virtually meaningless statistic in rural areas because it requires approximately 1,000 births to meaningfully record a relative frequency of deaths and most frontier communities record between 35-65 births/year. Many rural communities may go years without any infant deaths being recorded; yet if one infant death occurs, the rate suddenly but not meaningfully jumps to the worst in the country.

The same problem potentially exists with the other criteria. For example, in a remote rural setting, percentage of people below the poverty level may not be reflective of deficits in access to care because the issue may be one of too few residents to support a primary care provider rather than family income being below the poverty level. Percentage of elderly is not always a useful

measure of need either. For example, in a remote mining or oil field community, the residents might be highly transient, minimally educated, relatively well paid and very young, but lack the traditional family support that mediates health problems. In any case, MUA criteria they were originally intended, only suggested rates of infant mortality, and percentages of population below the poverty level and over 65 as determining factors.[2] These criteria were not intended to be limiting factors; however, because of rigid interpretations, regional and federal public health officials have penalized rural and remote communities.

In the process to obtain an MUA designation, data from the community in question is plugged into the government formula and added for each of four criteria mentioned. Any community yielding a score of 62 points or less, after the data has been weighted, is eligible to become MUA designatable. We witness communities which may have a score computed at 64 being excluded from any type of subsidized health care because there have not been any recent infant deaths.

[2] Report to the Congress of the United States, Comptroller General, June 15, 1981.

Ironically, in 1983 the town of Moorcroft in Crook County was the only site granted an MUA designation in Wyoming. Yet that community was least needy because it already had a satellite health center with rotating practitioners. No other town or community in the State of Wyoming has been eligible for an MUA designation (and subsequently eligible for federal funding) for the last seven years. Thus the town which met the criteria, was in fact one of the least needy communities by any logical assessment.

To resolve this problem of criteria which does not adequately reflect rural community needs, a contract between the Office of Rural and Community Health and the Region VIII Office in Denver was drawn up. This represented a consensus that Wyoming and other rural states may be poorly served by the MUA formula as presently interpreted. Needed money for communities lacking primary care services may be inappropriately denied based on a formula more appropriate for higher density populations.

No previous literature is available on this topic in rural/remote areas and as such it is not possible to site relevant citations or references on the topic.

OBSERVATIONS IN RURAL COMMUNITIES

During the past seven years eleven communities in Wyoming have been randomly and representatively surveyed to determine statistics on: hospital preferences, socio-economic factors, number of dwellers per household, potential support for local center, frequency/type/incidence of illness/injury, special type of health related needs and concerns, and hospital in the community. These indicators not only measure unmet health care needs, but also predict eventual economic support for the longevity of a health center.

Survey results provide a basis for recommendations to improve area health care. Results indicate that a center with the appropriate com munity profile may become self sufficient over a period of time. The number of households in the community is tabulated and multiplied by three, (the average number of members per household). Approximately 1,400 residents constitute a minimum population predicted to eventually provide a base for monetary success for the center. This can be offset with above average incomes ($20,000-$30,000) and/or higher frequency and incidence of illness/injury in the community.

In these rural/remote locations additional considerations should be made for the poor and elderly, recognizing above average costs for medical care--a factors which may offset population and financial considerations in the formulation of a health care plan. Similarly, consideration must be made for high winds, blowing snow and overall snow accumulation because roads may become either closed or dangerous in the winter.

As an interval measure, some communities may only be able to support an ambulance and/or Emergency Medical Technicians (EMT). County commissioners may be willing to finance ambulances to small communities provided that the residents demonstrate a commitment by training themselves (EMT I and II). Thus equipping an ambulance may become the initial type of medical service for a rural community. In addition, Public Health nurses can make weekly or bi-monthly visits to communities which do not have any type of medical service. Based on the experience of evaluating rural community health needs vs. services available, the surveyors have gained experience that can be translated into a modified MUA criteria for sparsely populated rural areas.

PROPOSED MUA CRITERIA

The proposed, modified MUA formula will take into account population, socio-economic data, weather adversity, geographical isolation and terrain, and average travel time/distance to a hospital providing secondary care.

This modified MUA formula will potentially allow needy rural communities to obtain MUA status for funding by the federal government. The modifications to the formula are appropriate because they take into account the diversities and adversities of climate and sparsely dispersed populations.

The following conditions apply to the modified MUA formula. 1. No other reliable primary care provision options are available (i.e. care offered by providers coming in by train, traveling van, etc). 2. Poverty statistics vary not only from community to community but from year to year. 3. The number of infant deaths does not adequately reflect the need for health services in a sparsely populated rural area. 4. The percentage of individuals 65 years of age or older in a community has little bearing on the overall need for health care services because most communities have the same proportion of elderly citizens. Census data is usually the only source available for statistics on poverty levels and population 65 and over, and this information is generally outdated.

The first criterion of the proposed modified MUA formula is T, and takes into account the travel time it is necessary to obtain medical services. If the travel time is longer than 55 minutes due to geographical isolation, weather adversity, or distance in miles, the population's health is clearly at risk. During the winter months, a 30 mile stretch of roadway may take 2½ hours to travel if blowing snow and "white-outs" are present, and on some roads this is a problem much of the year. The national standard of 30 minutes to health care is unrealistically low in a sparsely populated state by the very nature of the broadly dispersed population. Therefore it is proposed that the standard be increased in the modified MUA formula for sparsely populated rural areas to 55 minutes to primary care services. This lessening of national standards is to make the objective more reasonable and more obtainable.

The second criterion is O for the openness of the proposed area to primary care providers of medical care. This factor is determined by a census of physicians. Proposed MUA areas should not be contiguous to areas where the physician to population ratio is adequate (but in other rational primary care areas) where the physician/population ratio is less than 1 to 1,400.

The next criterion is P or the population. The minimum number of residents in an area is fourteen hundred. If the population is below fourteen hundred, it is highly unlikely that health care provision services can be established which can become self-sufficient in the long run. The absolute minimum of 1,400 is an attempt to take into account the socioeconomic climate of the community. These results are based on a random and representative survey in the area unless current census data is available.

The last part of the formula is E for efficacy. This is the ability or willingness to pay for health care in the frontier setting. This factor is also

determined by the socio-economic statistics gathered on an interview protocol administered by the Office of Rural and Community Health (ORCH). These random and representative surveys in select rural communities allow the staff to better predict the nature and support of various health care options for the rural communities. There is not only the socio-economic status to consider of the local clientele, but there is also the willingness of people in the community to use the proposed local health care service. Some may drive 60 miles under any conditions just to get out of their rural setting. A willingnesss to pay for health care in the frontier setting can help document sufficient financial support for the clinic and lower bad debt ratio (90% affirmative answer by residents on question dealing with willingness to support rural health center).

One then simply adds up these separate criteria and a point is given if evidence of the criterion exists. A total of four indicates all criteria have been met and an MUA designation should be considered by the Public Health Serivce.

Modified MUA Formula - Sparsely Populated Rural Model

A working formula for a rational primary health care district for frontier Wyoming includes the following variables:

A = F(T)+(O)+(P)+(E)

A = Actuality of MUA designation; total of 4 indicates sufficient need

F = Function of

T = Travel time (55 minutes or more) any indicator present = 1

O = Openness (no primary care services available in proposed area) if nonexistent or less than 1 provider/2500 residents = 1

P = Population (minimun 1,400) = 1

E = Efficacy(ability/willingness of residents to pay for health care); if present = 1

The actuality of a health center is thus determined by the values assigned to each component in the formula. A score of four indicates state level recommendation for MUA designation.

DISCUSSION-CASE STUDIES

This proposed MUA formula enables the state to suggest an area be considered by the Public Health Service MUA designatable. These criteria will probably be appropriate for most of the sparsely populated rural states and remote

communities. It enables those who are needy and deserving of some sort of federal support to qualify for it.

The federal level could additionally evaluate communities based upon criteria that they see as important such as the possible longevity of the community health center, (some sort of maximum number of areas to be designated as MUA's within a certain region or state). Equally qualified communities could be ranked ordered on the basis of population. Low birth weight and the potential of rural health clinics to improve that statistic may also be used as a weighting factor in rank ordering eligible MUA sites. This weighting formula could indeed put the final decision making process back at the federal level, but it would not negate the possibility of frontier areas receiving funds for adequate health care services.

The first example in the State of Wyoming would be the town of Medicine Bow which is 66 miles from Rawlins or Laramie (T=1). There are no primary care providers in the area (O=1). The population as estimated by the survey conducted by the Office of Rural and Community Health (ORCH) is 1,407 (P=1). The efficacy of the proposed health center's longevity was also determined by the ORCH study and 94% of the population would support the Center (E=1). T+O+P+E=4 and the state, thus, feels that the town of Medicine Bow should be designated as an MUA. In reality, the MUA status was not awarded the town of Medicine Bow because an infant mortality rate did not exist for the past five years, and as the formula is weighted it prevented a score of 62.

A second example might be the case of Bridger Valley. Presently there are nine thousand residents in the valley, and there is only one physician and her physicians' assistant. Potential physicians look at this situation and are afraid of burnout, afraid of no time for themselves and so the potentially dangerous situation goes on. (In doing the documentation for the MUA status 1980 census data was used and as such was totally inappropriate and did not document the case for MUA designation). It is 55 minutes to the closest hospital in Evanston (T=1). There are 1.5 primary providers for 9,000 residents(O=1). The population estimate as determined by a random study by ORCH revealed 9,000 inhabitants(P=1). The efficacy of the health center was 94% as determined by the ORCH study (E=1). T+O+P+E=4 and the state thus feels that Bridger Valley should be designated as an MUA. In reality Bridger Valley could not document either an infdant mortality rate or a percent below poverty because the newest census was over seven years ago and as such did not accurately portray the conditions in Bridger Valley, nor did it allow a score of 62 or less.

The TOPE dollar formula would reflect true need and long-term potential for these proposed health centers. It would more adequately reflect the need for health services based on a formula designed for use in a sparsely populated state where the residents are lacking medical services.

ATTACHMENT F

CONGRESS OF THE UNITED STATES OFFICE OF TECHNOLOGY ASSESSMENT

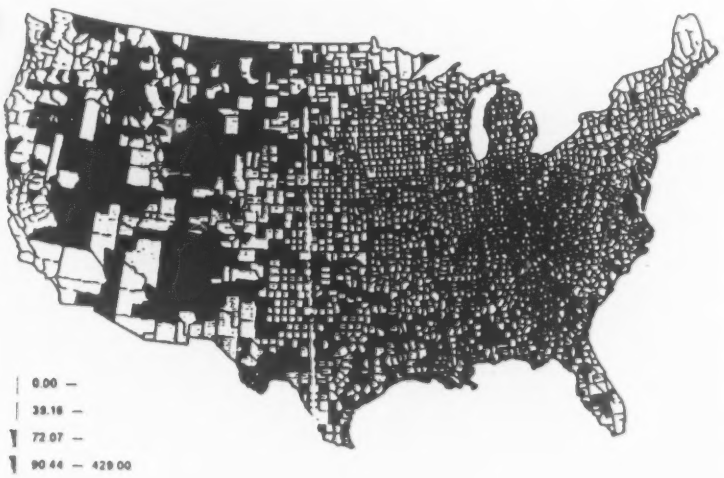
RURAL HEALTH CARE

DEFINING "RURAL" AREAS: IMPACT ON HEALTH CARE POLICY AND RESEARCH

July 1989

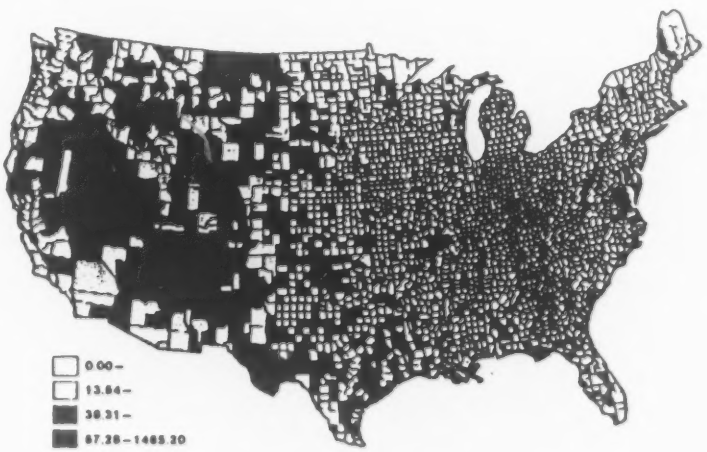
STAFF PAPER

Figure 7.--Death Rates Due to Unintentional Injury by County



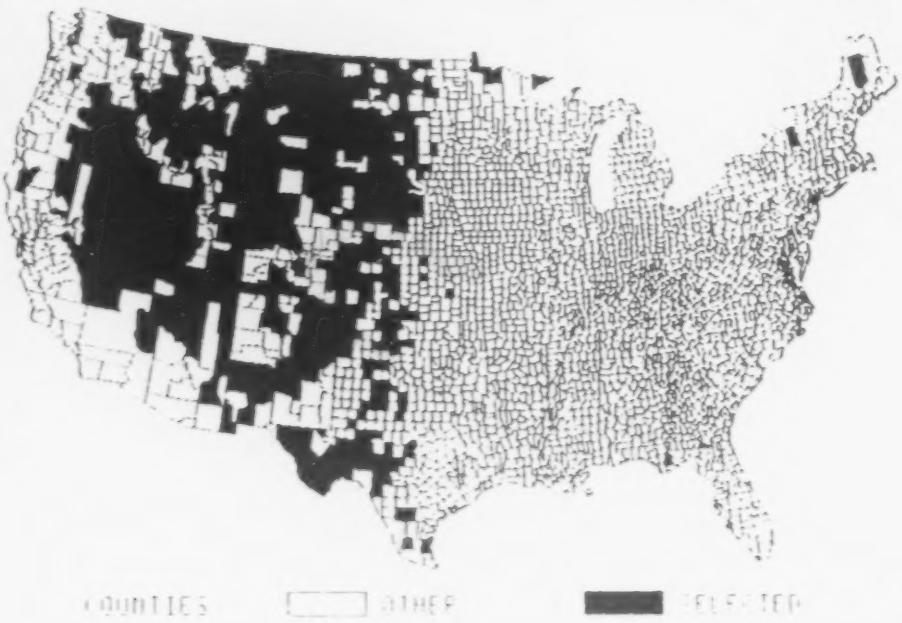
: Baker, S.P., Whitfield, R.A., and O'Neill, B., "County Mapping of Injured Mortality," The Journal of Trauma 28(6):741-745, June 1988.

Figure 8.--Death Rates Due to Motor Vehicle Crashes by County



SOURCE: Baker, S.P., Whitfield, R.A., and O'Neill, B., "Geographic Variations in Mortality from Motor Vehicle Crashes," New England Journal of Medicine 316(22):1384-1387, May 28, 1987.

Figure 9.--Frontier Counties: Population Density of 6 or Less



SOURCE: U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, Bureau of Health Professions, Office of Data and Management, Area Resource File, June 16, 1986.

hospital wage is 8.5 percent higher in urbanized rural counties than in nonurbanized rural counties (32). There are less than 125 nonMSA towns with 25,000 or more population, so few of the 2,393 nonMSA counties would be classified as urbanized (49). In fact, this distinction would create only 37 new areas (32).

Although HCFA has chosen not to use urbanized areas to refine labor market areas, HCFA does use urbanized area designations when certifying hospitals and clinics under the Rural Health Clinic Act. Rural Health Clinics must be located in nonurbanized areas that are designated as either a health manpower shortage area or a medically underserved area. This liberal interpretation of "rural" (e.g., it includes some areas within MSAs) seems appropriate, given the requirement that the area must also be medically underserved. This allows some medically underserved areas within MSAs--but isolated from an urbanized area by factors other than distance--to be certified.

Providing Services in "Frontier" Areas

Health services may be difficult to provide in large, sparsely populated areas. Areas with a population density of 6 persons per square mile or less, called "frontier" areas, are common West of the Mississippi river (30) (figure 9). In 1980, by this definition, there were at least 378 frontier counties with a total population of nearly 3 million persons (42). It may take an hour or more for residents of frontier areas to reach health providers and facilities. Frontier physicians tend to be generalists, solely responsible for a large service area, and have limited access to hospitals and health care technology (11). Recognizing the unique characteristics of frontier areas,[7] DHHS in early 1986 agreed to use different criteria to evaluate Community Health Center (CHC) grantees (and new applicants for CHC support) and National Health Service Corps sites.[8] Frontier areas were defined as (59):

> Those areas located throughout the country which are characterized by a small population base (generally 6 persons per square mile or fewer) which is spread over a considerable geographic area.

To be eligible for Bureau of Health Care Delivery and Assistance (BHCDA) support as a frontier area, the following service area criteria must be met (59):[9]

> **Service Area:** a rational area in the frontier will have at least 500 residents within a 25-mile radius of the health services delivery site or within the rationally established trade area. Most areas will have between 500 to 3,000 residents and cover large geographic areas.
>
> **Population Density:** the service area will have six or fewer persons per square mile.
>
> **Distance:** the service area will be such that the distance from a primary care delivery site within the service area to the next level of care will be more than 45 miles and/or the average travel time more than 60 minutes. When defining the "next level of care," we are referring to a facility with 24-hour emergency care, with 24-hour capability to handle an emergency caesarean section or a patient having a heart attack and some specialty mix to include at a minimum, obstetric, pediatric, internal medicine, and anesthesia services.

---

7 The Frontier Task Force of the National Rural Health Association (established in 1985) was instrumental in documenting the unique health care needs of rural areas (63).

8 The 1988 authorizing legislation for Public Health Service programs of assistance for primary health care included recommendations for DHHS to support primary health care planning, development, and operations in frontier areas (46).

9 If the eligibility criteria are not strictly met, an organization may justify any unusual circumstances which may qualify them as frontier, for example, geography, exceptional economic conditions, or special health needs (59).

Some State Health Departments have had trouble identifying service areas meeting these criteria (26). Whole counties can be identified as frontier areas on the basis of population density, but available sub-county geographic units are sometimes inadequate for identifying health service areas. Population data from the 1980 Census are available for sub-county areas such as Census County Divisions (CCDs), and Enumeration Districts (EDs) (see appendix D) but these areas can be large and may not represent a rational health service area.[10] ZIPCodes[11] may be aggregated to form a rational service area, but this poses some technical difficulties (19). Following the 1990 Census, Block Numbering Areas will be available for all nonurbanized areas (see appendix D.--1980 Census geography).[12]

It is useful to distinguish frontier area counties with evenly distributed small settlements from counties with one or two large population settlements and large areas with little or no settlement. For example, the health service needs of two frontier counties in New Mexico with similar population densities differ because of the way the populations are distributed. One county has a total population of approximately 8,000, of whom about 6,000 live in one town. In contrast, the other county has a total population of 2,500 living in six widely dispersed towns. If suitable sub-county areas were available, the Hoover Index, which measures population concentration or dispersion, could be used to distinguish between these counties. An automated geographic information system called TIGER (Topologically Integrated Geographic Encoding and Referencing System) has been developed[13] that will enhance the ability to conduct spatial analyses of population data from the 1990 decennial census (23).

10 Some States have defined primary care service areas (e.g., New York).

11 Population data from the Census are available by ZIPCode. Some investigators have used ZIPCode-level census data to describe three types of rural area based upon density within zip code: semi-rural (density of 16 to 30 per square mile); rural (density 6 to 15 per square mile; and frontier (density less than 6 per square mile) (10).

12 In 1980, Block Numbering Areas were only available for nonurbanized places with over 10,000 population.

13 TIGER has been developed jointly by the U.S. Geological Survey and the U.S. Bureau of the Census.

Congressional Office of Technology Assessment

Workshop on Health Professions and Frontier Issues and Strategies
Tentative Meeting Agenda
February 8, 1989

7:30 a.m. – 8:00 a.m.
Continental Breakfast

8:00 a.m. – 10:00 a.m.
Session One: Physician Training, Distribution, Practice and Retention Issues

Invited Panelists:
Gerald Sailer, M.D., Hettinger, North Dakota
Frank Newman, Western Montana Area Health Education Center, Montana
Nelson Tilden, MSCI, Overland Park, Kansas
Carol Miller, Mountain Management, Ojo Sarco, New Mexico

10:00 a.m. – 10:15 a.m.
Break

10:15 a.m. – 12:15 p.m.
Session Two: Nurse Training, Distribution, Practice and Retention Issues

Invited Panelists:
Karen Pederson-Hawley, Lake Regional District Health Unit, Devils Lake, ND
Lois Merrill, Dean, School of Nursing, University of ND, Grand Forks, ND
Sue Ebertowski, Mercy Hospital, Williston, ND
Jan Towers, American Academy of Nurse Practitioners, Lowell, MA

12:15 p.m. – 2:00 p.m.
Lunch break

2:00 p.m. – 4:00 p.m.
Session Three: Other Health Professions Training, Distribution, Practice and Retention Issues

Invited Panelists:
John Mengenhausen, East River Health Care, Howard, SD
Tom Robertson, SE Montana RHI, Glendive, MT
Denise Denton, Utah Department of Health, Salt Lake City, UT
Dwane Ollerich, Academic & Research Affairs, UND, Grand Forks, ND

Congress of the United States
Office of Technology Assessment
Workshop on Health Professions and Frontier Issues and Strategies
February 28, 1989
Bismarck, North Dakota

Physician Training, Distribution, Practice and Retention Issues
Carol Miller, MPH

Importance of Frontier Areas to the Nation

45% of the land area of the US (using counties of 6 or fewer/sq mi)

great wealth produced by these areas for the nation (agriculture, livestock, timber, mining, oil and gas, water, electricity, tourism and recreation, etc)

critical to our national defense; location of many major military installations with both civilian and uniformed workforce

small population does not receive back in federal programs and/or funds an amount even close to what is contributed

PROBLEM STATEMENT

Cutbacks in Federal Funding

Most state and local governments have not been able to adequately take over programs cutback by the federal government - isolated and all low income communities have suffered the greatest reductions in access to care

Physician Distribution

Federal projections of physician diffusion in the 70's and early 80's assumed that rural and frontier areas would ultimately become more desirable to physicians

recent studies indicate that diffusion is not working in many rural and inner city areas and has completely failed to meet the need of most frontier areas

> "Although the increasing supply of physicians and other health care personnel appear to have alleviated some health care personnel distribution problems, many geographic areas appear to lack sufficient practitioners to assure adequate access to care. About 13 million persons or about 5 percent of the U.S. resident population remain underserved in the Nation's primary care health manpower shortage areas.
>
> Continued increases in the supply of health care personnel are expected to improve access for some areas. However, population and economic factors may remain unfavorable for the establishment of health care practices in many rural and urban poverty area. Thus, such areas are likely to continue to remain short of adequate health care."
>
> Sixth Report to the President and Congress On the Status of Health Personnel in the United States, June 1988 (HRSA)

Federal manpower policy has not adapted to the realities of current information and in many cases, these policies have worsened the distribution of physicians in frontier areas, for example:

- severe reductions in the National Health Service Corps (NHSC) the only program in our nation's history which placed health professionals in frontier areas by combining the concept of service as payment for financial aid and stiff penalties for non-repayment
- 1986 study of the NHSC by Carol Miller found that the NHSC had 190 health professionals in frontier communities in 14 states in PHS Regions 6,7,8,9,10
  - 53 federally-paid providers (50 MD, 12 DDS, 4 DO, 5 NP, 1 POD, 1 DIR)
  - 137 providers were PPO (Private Practice Option) with the community bearing the expense of establishing and supporting the practice
- retention studies need to be done to see how many of the PPO's were actually able to establish viable practices and how many vacancies were created as NHSC obligations were fulfilled with no new scholars to replace them
- frontier areas should be exempted from federal policies that require Commissioned and National Health Service Corps personnel to move at regular intervals through their career - it is very rare that providers want to stay in frontier areas, why move the few who prefer a career in frontier health care

SOLUTIONS

Reduce medical indigency

medical indigency, the inability to pay for health care, is a primary barrier to access

Expand Medicaid

Medicaid eligibility and types of services provided should be the same in all states

Tax credits/Tax incentives

the New Mexico Legislature is now considering legislation (SB 258) to provide a tax credit on state income tax, to physicians active in the New Mexico Medicaid program

many states and the Federal government are investigating tax credits for small employers to help them insure their employees

National Health Service Corps

provide stipends for family practice physicians during residency - not at medical school

target only hardest to fill vacancies - frontier and inner city

Training

establish rotations in rural/frontier settings

establish chairs, fellows, and professorships in rural health within medical schools; make it prestigious to be a rural physician

provide opportunities for mentoring while in training

Retention

federal government provide locum tenens physicians to states (cooperative agreement contractors, offices of rural health) to assure availability of coverage for vacations and CME

states and sites provide stress management, critical incident stress services

Board and administration training to learn how to treat staff with respect

expand availability of mid-level providers to share the workload of rural practices

financial incentives/tax credits for professional staff

need strong EMS and referral systems

Federal funding

expand the NHSC

mandate setasides in section 330, the Community Health Center program, for frontier health centers

open PHS special initiatives funding to non-CHC's

facilitate application and re-application of small sites seeking limited funding

develop specific evaluation criteria appropriate for frontier projects

ATTACHMENT G

FRONTIER COMMUNITY/MIGRANT HEALTH CENTERS
by State

BCRR# 329/330 Site Name/Address	County	Frontier Criteria
091300 Lake Powell Medical Center Page, AZ	Coconino	Fewer than 6 persons/square mile
091960 Northeast Rural Health Clinics, Inc. Susanville, CA	Lassen	
080010 Colorado Migrant Health Program Granada, CO Services in frontier counties of	Baca Bent Kit Carson	
080010 Colorado Migrant Health Program Fort Morgan, CO Services also in frontier counties of	Sedgwick Washington Yuma	
Main site is #080010--Colorado Migrant Health Program, Denver, CO, and is not in a frontier area		
080100 Dolores County Health Association Dove Creek, CO	Dolores	
08003D San Luis Health Center San Luis, CO	Costilla	
08003A Saguache Clinic Saguache, CO	Saguache	
08003B Family Health Center Center, CO	Saguache	
08003C Guadelupe Health Center Antonito, CO	Saguache	
Main site is #080030--Valley Wide Health Services, Inc., Alamosa, CO, and is not in a frontier area		

BCRR# 329/330 Site Name/Address	County	Frontier Criteria
081740 Uncompahgre Combined Clinics Norwood, CO	San Miguel	Fewer than 6 persons/square mile
10028B Horseshoe Bend Health Clinic Horseshoe Bend, ID	Boise	
10028C Garden Valley Health Center Garden Valley, ID	Boise	
10028D Pioneer Medical Clinic Pierce, ID	Clearwater	

10028E
Salmon River Emergency Clinic
Stanley, ID — Custer

Main site is #100280--Mountain Health Clinics, Inc., Nampa, ID, and is not in a frontier area

10018A
American Falls Medical Clinic
American Falls, ID — Power

10016B
Homedale Clinic
Homedale, ID — Owyhee

10016D
Marsing Clinic
Marsing, ID — Owyhee

Main site is #100160--Health West, Inc., Pocatello, ID, and is not in a frontier area

101630
Valley Family Health Care
Payette, ID — Washington

05270B
Grand Portage Clinic
Grand Portage, MN — Cook

052700
Cook County Community Clinic
Grand Marais, MN — Cook

082110
Mercer Oliver Health Services, Inc.
Center, ND — Oliver — Fewer than 6 persons/square mile

082160
Montana Migrant Council
Hardin, MT — Big Horn

082160
Montana Migrant Council
Bridger, MT — Carbon, Stillwater, Sweetgrass

082160
Montana Migrant Council
Glendive, MT — Custer, Dawson, Fallon, Prairie, Wibaux

082160
Montana Migrant Council
Sidney, MT — Roosevelt, McKenzie, N.D.

06033C
HCNM San Miguel Clinic
Ribera, NM — San Miguel

06033G

HCNM Roy Clinic
Roy, NM — Rio Arriba

06033L
HCNM La Loma Clinic
Antoon Chico, NM — Rio Arriba

060330
Health Centers of Northern New Mexico (HCNM)
Espanola, NM — Rio Arriba

09157A
Lincoln County Medical Clinic
Caliente, NV — Lincoln

09157C
Beatty Medical Clinic
Beatty, NV — Nye — Fewer than 6 persons/square mile

09157D
Eureka County Medical Clinic
Eureka, NV — Eureka

09157F
Alamo Medical Clinic
Alamo, NV — Lincoln

09157M
Amargosa Valley Medical Clinic
Amargosa Valley, NV — Nye

09157O
Central Nevada Rural Health Consortium
Hawthorne, NV — Mineral

02179C
Indian Lake Health Center
Indian Lake, NY — Hamilton

Main site is #021790--Hudson Headwaters Network, Warrensburg, NY, and is not in a frontier area

10001C
North Lake County Health Center
Christmas Valley, OR — Lake

Main site is #100010--Southeast Oregon Rural Health Network, Chiloquin, OR, and is not in a frontier area

101630
Valley Family Health Care
Payette, OR — Malheur

101630
Nyssa Health Care
Nyssa, OR — Malheur

081610
Rosebud Health Clinic
Rosebud, SD — Todd
Transferred to Indian Health Service effective 12/1/89

082100
Isabel Community Clinic
Isabel, SD — Dewey — Fewer than 6 persons/square mile

080590
Rural Health Care, Inc.
Pierre, SD — Jones

081690
Tri-County Health Care, Inc.
Wessington Springs, SD — Jerauld

080680
The Brotherhood Community Health Board
Porcupine, SD — Shannon

06074C
United Medical Centers #2
Brackettville, TX — Kinney

Main site is #060740--United Medical Centers, Inc., Eagle Pass, TX, and is not in a frontier area

060951
South Plains Health Provider Organization
Matador, TX — Motley

Main site is #060950--South Plains Health Provider Organization, Plainview, TX, and is not in a frontier area

060970
Community Health Clinic
Hebronville, TX — Jim Hogg

Main site is #060970--Community Action Council of South Texas, Rio Grande City, TX, and is not in a frontier area

06265D
Vega Health Center
Vega, TX — Oldham

Main site is #062650--Panhandle Rural Health Center, Amarillo, TX, and is not in a frontier area

062120
South Texas Rural Health Services, Inc.
Cotulla, TX — La Salle

06071C
Cross Timbers Health Clinic #3
San Saba, TX — San Saba — Fewer than 6 persons/square mile

Main site is #060710--Cross Timbers Health Clinics, Inc., De Leon, TX, and is not in a frontier area

080510
Utah Rural Development Corporation
Provo, UT — Iron

080510
Utah Rural Development Corporation
Midvale, UT — Tooele

082490
Green River Community Health Center
Green River, UT — Emery

082240
Wayne County Medical Clinic
Bicknell, UT — Wayne

10036G
Kettle River Medical Center
Orient, WA — Ferry

10036H
Loon Lake Clinic
Loon Lake, WA — Ferry

Main site is #100360--Northeast Washington Health Programs, Chewelah, WA and is not in a frontier area

100610
Family Medical Center
Walla Walla, WA — Columbia

080830
Goshen-Platte County Health Project
Guernsey, WY — Platte/Wheatland

080710
Northwest Community Action Programs of Wyoming (NOWCAP)
Worland, WY — Washakie
Fremont
Hot Springs

ATTACHMENT H

8601: Frontier and Rural Health: Agenda for Action

The American Public Health Association,

Recognizing that rural populations in the United States continue to experience shortages of health practitioners, and that there is a diversity in rural health care needs; and

Noting that health policies do not take into account the wide range of diversity among rural communities, so that the term "rural" is used to describe both suburban areas adjacent to major cities as well as totally isolated areas with small populations located 100-200 miles from urban areas; and

Observing that in the 1980 Census, there were 143 counties with fewer than two persons per square mile, and that 294 counties may be defined as frontier areas having six or fewer persons per square mile and located more than 45 miles from the next level of care, and that frontier areas comprise 45 percent of the United States land area;[1,2] and

Affirming that the facts do not support the reasoning or conclusion that an aggregate surplus of health care providers results in an adequate supply in rural areas; and

Finding that a large number of researchers are unanimous in casting doubt on the notion that physicians will diffuse to rural areas when urban areas become too competitive, and that, even if the diffusion theory were operative, the cost of training seven to ten physicians to assure that one will diffuse to a non-metropolitan county is too high;[3-7] and

Acknowledging that among nonmetropolitan counties which did gain in health care providers and providers-to-population ratios, the larger numbers were those which enjoyed economic and geographic advantages and were already well endowed with health care providers; and

Noting that many studies have documented the exclusion of many rural areas, especially frontier areas, from changes in the health care environment, such as health maintenance organization (HMO) development, increasing numbers of health care providers and alternative health care delivery systems;[8-10] and

Understanding that many major health care developments are not occurring in rural and frontier areas because of low population density, high levels of poverty, and limited financial support for health services, so that less primary care is accessible and available to the people in rural and frontier areas, and gaps in health care are increasing; and

Affirming that diffusion and competition theories will not assure an adequate supply of health care providers in rural areas; and

Concluding that health care provider shortages continue in rural and frontier underserved areas; therefore

1. Recommends the provision of financial incentives for an integrated approach to health services resources in rural and frontier areas, including public health departments, community health centers, and programs that serve populations with unique needs such as migrants, Indians, and veterans;

2. Renounces the notion of a diffusion-based rural health policy as the sole basis for providing underserved areas with appropriately trained physicians and other health personnel;

3. Endorses a policy and the maintenance of adequate funding for training programs that encourage health care providers to locate in rural and frontier areas, thus increasing provider-to-population ratios to levels that will ensure access to adequate health care. Examples of these primary care training programs include:

- Primary care medical recruitment, education, and training programs such as Area Health Education Centers; and
- Scholarship, loan and loan forgiveness programs with provisions for service in rural, underserved, and frontier areas, such as the National Health Service Corps;

3. Encourages equitable health programs and policies which reflect the diversity of rural areas and specifically the needs and rights of people living in frontier areas. For example:

- the development of reimbursement schedules for Medicare, Medicaid, and other third party sources which eliminate discrimination against the rural and frontier providers and offer incentives for rural practice.

References

1. Frontier Health. Rural Primary Care. National Rural Health Care Association. November/December 1984.
2. Draft Defining Characteristics. Frontier Task Force. National Rural Health Care Association and Region VII. US Public Health Service.
3. Health Resources Administration. US Public Health Service: Summary Report of the Graduate Medical Education National Advisory Committee. DHHS Pub. No. (HRA) 81-651. April 1981.
4. Ahearn MD, Pryar MD: Physicians in Nonmetro Areas during the Seventies. Washington, DC: USDA. March 1985 (Rural Development Research Report, No. 46).
5. Cordes SM, Eisele TW: Changes in Pennsylvania's physician supply. Pennsylvania Med 1985;88:55-8.
6. Cordes SM, Eisele TW: Another look at the Rand studies on physician diffusion. Rural Primary Care. NRHCA. May/June 1984.
7. Freun MA, Cantwell JR: Geographic distribution of physicians: Past trends and future influences. Inquiry 1982;19:44-50.
8. Hicks LL: Social policy implications of physician shortage areas in Missouri. Am J Public Health 1984;74:1316-1321.
9. Ellwood Proposes Rural Supermed. Rural Primary Care. NRHCA. May/June 1985.
10. Rickets TC, Guild PA, Shess CG, Wagner EH: An evaluation of subsidized rural primary care programs: III. Stress and survival. Am J Public Health 1984;74:816-819.

ATTACHMENT I

Mr. Chairman, this legislation simply is an investment in our Nation's future. Healthy babies will one day become healthy, productive workers and contributing members of our society. Babies born to young mothers who do not receive health care early on will never get that chance.

Mr. Chairman, I hope that all my colleagues will see fit to support this very important piece of legislation.

Mr. WAXMAN. Mr. Chairman, I yield 3 minutes to the gentleman from Utah [Mr. NIELSON].

Mr. NIELSON of Utah. Mr. Chairman, today I rise in support of H.R. 1326, the Public Health Service Infant Mortality Amendments Act of 1987. As you may be aware, recent studies have found that the United States has progressed far less than other industrialized nation in reducing rates of infant mortality. During the years 1950–55, the U.S. rate of infant mortality ranked sixth among 20 industrialized nations. This ranking progressly declined during the years 1980–85 until it ranked very last.

In 1980, the Surgeon General of the Public Health Service established the 1990 health objectives for the Nation with respect to prenatal care and rates of infant mortality. It now appears that the United States will fail to meet these health objectives with respect to the provision of prenatal care early in pregnancy and with respect to reducing the incidence of low birth weight births and of infant mortality. There is clear and convincing evidence that this inadequate care occurs most frequently among individuals who are poor and without health insurance.

H.R. 1326 enables community and migrant health centers to provide health care to additional children, and women of childbearing age, who are poor or have inadequate health insurance, and to enhance the role of such programs in efforts to meet the 1990 health objectives.

Included in this bill is the "frontier amendment," which I sponsored, that requires the Secretary of the Department of Health and Human Services to "give special consideration to the unique needs of frontier areas" in the funding of community health centers. As you know, frontier areas include those areas having a population density of six or less persons per square miles. Frontier areas are located primarily in Western States, with 394 counties and 45 percent of the U.S. land area being frontier. Many States have high percentages of frontier areas. For example, based upon square miles in each county, frontier areas include 96 percent of Alaska, 84 percent of Nevada, 83 percent of Utah, 62 percent of Idaho, 61 percent of Montana, 52 of New Mexico, 50 percent of Oregon, 47 percent of Nebraska, 61 percent of North Dakota, 65 percent of South Dakota, 20 percent of Washington, 29 percent of Kansas, and 83 percent of Wyoming.

Health care service in frontier areas is sparse. In many instances home health aides and volunteer emergency medical technicians are the primary care providers. Often, even these do not exist. The hospitals in frontier areas are small, usually with less than 25 beds. Consequently they are very vulnerable to economic cycles and staff shortages. Nationally about 220 hospitals are frontier hospitals. Frontier hospitals are frequently the only source of health care for an area.

Reimbursement policies often have unintended negative consequences upon these facilities. Due to distance and remoteness, the costs for utilities, supplies, food, and labor are often higher than average costs. A large portion of the patients in the frontier areas are neither Medicaid nor Medicare eligible. Federal reimbursement does not cover the costs of providing the care. The facilities cannot recover the revenue lost in serving patients whose care is paid for by the Federal Government because there are not enough private-pay patients, and many of the private-pay patients have no insurance and have household incomes near the poverty level.

Mortality data indicates that the frontier areas have a higher rate of working years of life lost than do the rural or urban areas for the following leading cases of death: Motor-vehicle accidents, diseases of early infancy, non-motor-vehicle accidents, heart disease, and stroke. In the last 2 years the rate for suicides in frontier areas has increased significantly.

A number of professional organizations have acknowledged frontier areas. Others, including the Rural Health Care Association, the American Public Health Association, the National Association of Counties, and the American Academy of Family Physicians have adopted resolutions showing their support for the concept. Like us, they are also working to find solutions to delivery, reimbursement, health status, and manpower shortages in these areas.

For these reasons, I strongly support H.R. 1326. I urge all my colleagues to vote in favor of this legislation which is so vital to our Nation.

Mr. DURBIN. Mr. Chairman, I rise today in strong support of the Public Health Service Infant Mortality Amendments Act. The legislation, which increases the authorization levels for community and migrant health centers, is designed to help reduce our outrageously high infant mortality rate by targeting the health improvement of high-risk pregnant women and children.

Community and migrant health centers provide basic health services in some of our country's neediest communities. Of the families served by the health centers: 80 percent have incomes below the poverty level; 48 percent lack health insurance of any kind; 44 percent live in isolated rural areas; and 80 percent are high-risk women and children. There is clearly a valuable role that these centers can play in improving access to care among the medically underserved.

In my downstate, Illinois district, the Community Health Improvement Center, which serves the people of the city of Decatur and Macon County, is a shining example of the values of this important source of cost-effective, primary care. Last year this health center served over 6,000 low-income individuals and Medicaid recipients. Without community and migrant health centers, many families would be without even basic medical care.

Increasing the funding for community and migrant health centers for the purposes of infant mortality reduction is in keeping with the children's initiative in the budget resolution and with the Surgeon General's 1990 infant health objectives.

The adoption of this legislation is a vital component to the continuing fight against infants born at low birthweight and infant mortality in this country. Progress in reducing the infant mortality rate in the United States has come to a virtual standstill. America's infant mortality ranking among 20 industrialized nations has made a dramatic decline from sixth to a tie for last place. As our medical technology advances, our success rate in keeping babies alive is deteriorating at a shameful pace.

The National Academy of Sciences has estimated that low-birthweight infants are 40 times more likely to die in the first year than other infants, and face a much greater risk of developing serious health problems and disabilities. Few dispute that the key to insuring the birth of a healthy baby is prenatal care. Pregnant women who receive no prenatal care are three times more likely to deliver a low-birthweight baby than women who see a doctor early and regularly during their pregnancy. Low birthweight births could be reduced by up to 15 percent, and an even higher percentage of birth defects could be prevented through good prenatal care.

While amazing advances in technology have allowed us to keep low birthweight infants alive, it is likely that many will be faced with long-term disabilities and may require special educational and social services throughout their lifetimes. Each child in a neonatal intensive care unit costs an average of $1,000 a day and the average stay is 22 days. More than $2.5 billion is spent annually on neonatal intensive care services in the United States.

These are shocking figures in light of the estimates that every dollar spent on prenatal care can save over $3 in the cost of caring for a low-birthweight infant.

It is time that this country make a real commitment to identifying and serving low-income and uninsured women and children. This important, cost-effective legislation is a necessary step toward reducing our Nation's unacceptably high infant mortality rate. I urge you to support the Public Health Service Infant Mortality Amendments Act.

Ms. PELOSI. Mr. Chairman, I rise today in support of H.R. 1326, the Public Health Service Infant Mortality Amendments Act. This important bill increases the authorizations for community health centers and migrant health centers. Among 20 industrialized countries, the United States has declined from a rank of sixth in 1950 to last place. This situation is deplorable. Two-thirds of all infant mortality can be attributed to low birthweight, a condition

the administration I believe these clinics can be sustained with a modification in the proposed policy. I ask to have in the RECORD a copy of a letter I received recently from Dr. Ed Martin, Acting Deputy Administrator of the Health Resources and Services Administration. This explains their intention to assure there will be no reduction in the proportion of funds available for small, rural clinics.

The letter follows:

HEALTH RESOURCES AND SERVICES ADMINISTRATION,
Rockville, MD, March 27, 1986.

Hon. ORRIN HATCH,
U.S. Senate,
Washington, DC.

DEAR SENATOR HATCH: Your staff requested that the Public Health Service provide you with some written assurance that the concerns expressed by Dr. Dandoy in her letter of March 19 would be addressed by the Bureau of Health Care Delivery and Assistance (BHCDA).

By way of background, let me say that all Community Health Centers (CHC) grantees are being reviewed in the areas of governance, clinical systems and financial/administrative structure. These reviews are intended to ensure that centers meet all statutory and regulatory requirements prior to receiving grant funding. In addition, in view of funding constraints, the Public Health Service (PHS) has established priorities for funding.

All CHCs must be governed by a community board with center users comprising a majority of members. The board must fulfill all functions and responsibilities specified in legislation and regulations. Centers which meet these requirements through a compliant arrangement, where the community board is not the recipient of the grant, are a lower priority for funding than those whose board receives the grant directly.

Regarding clinical systems, a CHC must provide to the residents of its catchment area the statutorily required primary care services, available and accessible promptly, as appropriate, and in a manner which will ensure continuity. In addition, a CHC must provide sufficient staff, qualified by training and experience, to carry out its activities. In implementing these requirements, the PHS gives priority to systems of care that have appropriate physician coverage, including appropriate after-hours coverage and hospital arrangements.

In the financial/administrative area, CHCs must maximize nongrant revenues and utilize, to the greatest extent possible, other Federal, State and local, and private resources.

The three small rural CHCs in Utah cited by Dr. Dandoy have not been marked for defunding. They have been identified, however, along with a significant number of other projects throughout the country, for an indepth review. This review is for the purpose of determining whether the current delivery system is the most appropriate and efficient model to meet the needs of that particular community. It may be possible for example, to strengthen a CHC's clinical system through shared services or consortia arrangements with other CHCs and private providers. In this context, we are looking at the uniqueness of "frontier" areas. This process began in early 1985 with the establishment of a frontier medicine task force comprised of Federal, State and project personnel from the western region of the country.

[illegible] to complete a draft policy paper, addressing frontier health issues, by early April. We will circulate this policy paper to a broad spectrum of interested people for input including: State Health Agencies; State Primary Care Associations; National Rural Health Care Associations; and National Association of Community Health Centers. We expect to issue a final document by the end of April which would establish the basis for reviewing frontier sites in terms of Federal grant support (CHC) or manpower support (National Health Service Corps). This document will assure no reduction in the proportion of available grant support for projects falling under this definition.

It remains our intent to maintain the current rural/urban split in appropriated funds. You may be interested to know that expenditures in rural areas increased by 11.1 percent from Fiscal Year 1984 to Fiscal Year 1985 while total appropriation increased by 8.2 percent.

I have assured Dr. Sundwall that any proposed decisions at the regional office level which might be viewed as adversely affecting frontier projects in Utah, will be carefully reviewed by me personally prior to any proposed adverse action. Should you have questions or continued concerns about our approach to the unique circumstances of "Frontier" projects, I will be pleased to respond further to them.

Sincerely yours,
EDWARD D. MARTIN, M.D.,
Assistant Surgeon General,
Acting Deputy Administrator.

Mr. President I encourage all of my colleagues to join with me in approving this bill immediately. I have assurances from the administration that this bill will be signed into law, maintaining the authority for these important clinics.

REAUTHORIZATION OF THE COMMUNITY HEALTH CENTERS AND MIGRANT HEALTH CENTERS PROGRAM

Mr. KENNEDY. Mr. President, I rise in support of the reauthorization of the Community Health Centers and Migrant Health Centers Programs, and urge the Senate to adopt the bill already passed by the House.

This legislation before us today will help ensure the continued development and vitality of community-based health centers. Community health centers have provided essential health services to those most in need for more than 20 years. Study after study has shown that community health centers provide high-quality, cost-effective care to those who would otherwise lack access to essential health services.

Last year alone, community health centers were the primary source of health care services to more than 5 million Americans. Because community health centers are such attractive and effective providers of primary care services, the Federal grant dollars provided leverage services valued at more than twice as much as the direct Federal grants, including funding by Medicare, Medicaid, State programs, private insurance, and patient fees.

The need for community health centers is greater today than ever before. The number of Americans without health insurance has increased 48 percent since 1977, from 25 million people to 37 million. The number of the poor and near poor without Medicaid coverage has increased from 37 percent to more than 50 percent during the same period. Community health centers obviously cannot fill all these gaps, but they are a key resource in providing care to the poor and the underserved at a time when other institutions in our society are doing less and less to meet these important needs.

In addition to reauthorizing the Community Health Centers Program, this legislation includes several important improvements. It encourages expanded activities by State governments in primary health care by establishing a new program of grants to the States for planning and development of primary care services. At the same time, the legislation includes several provisions designed to encourage even more effective coordination of State and Federal primary care activities.

Just as the community health centers have provided essential health services to the poor and underserved in urban and rural areas throughout the country, migrant health centers have provided health services to one of the most deprived groups in our society—migrant farmworkers. For this group in particular, the services of health centers have often literally meant the difference between life and death.

I am disturbed by the authorization levels of $400 million included in this bill for fiscal year 1987 and fiscal year 1988. This is substantially below the Senate level and only slightly above the fiscal year 1986 appropriations. In view of the growing crisis in access to health care, I believe additional increases in the Community Health Centers Program are warranted.

Despite my concern over these authorization levels, I am supporting this bill because I have been informed that the House bill will be signed by the President. Higher authorization levels might not pass the House and might not be signed if passed. Because this program is so essential, its maintenance should be our highest priority. Nevertheless, I believe serious consideration should be given to raising the authorization levels next year.

As the Community Health Centers Program enters its third decade, we, in the Congress, can express our satisfaction with their accomplishments and our recognition of the continued need for a Federal commitment to health care for the poor and underserved by prompt passage of this legislation.

Mr. RUDMAN. I move to concur in the House amendment.

The motion was agreed to.

Mr. RUDMAN. I move to reconsider the vote.

Mr. BYRD. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

"(B) No application for a grant under subsection (d) of this section from a center or project that received such a grant in the prior year shall be denied in whole or in part unless there is cause and the center or project has first been afforded reasonable notice and opportunity for a hearing on the record before the Administrator of the Health Resources and Services Administration.".

SEC. 103. REQUIREMENT WITH RESPECT TO FRONTIER AREAS.

Section 330 (42 U.S.C. 254c) is amended by adding at the end thereof the following new subsection:

"(j) In making grants under this section, the Secretary shall give special consideration to the unique needs of frontier areas.".

SEC. 104. ADMINISTRATION OF PROGRAMS.

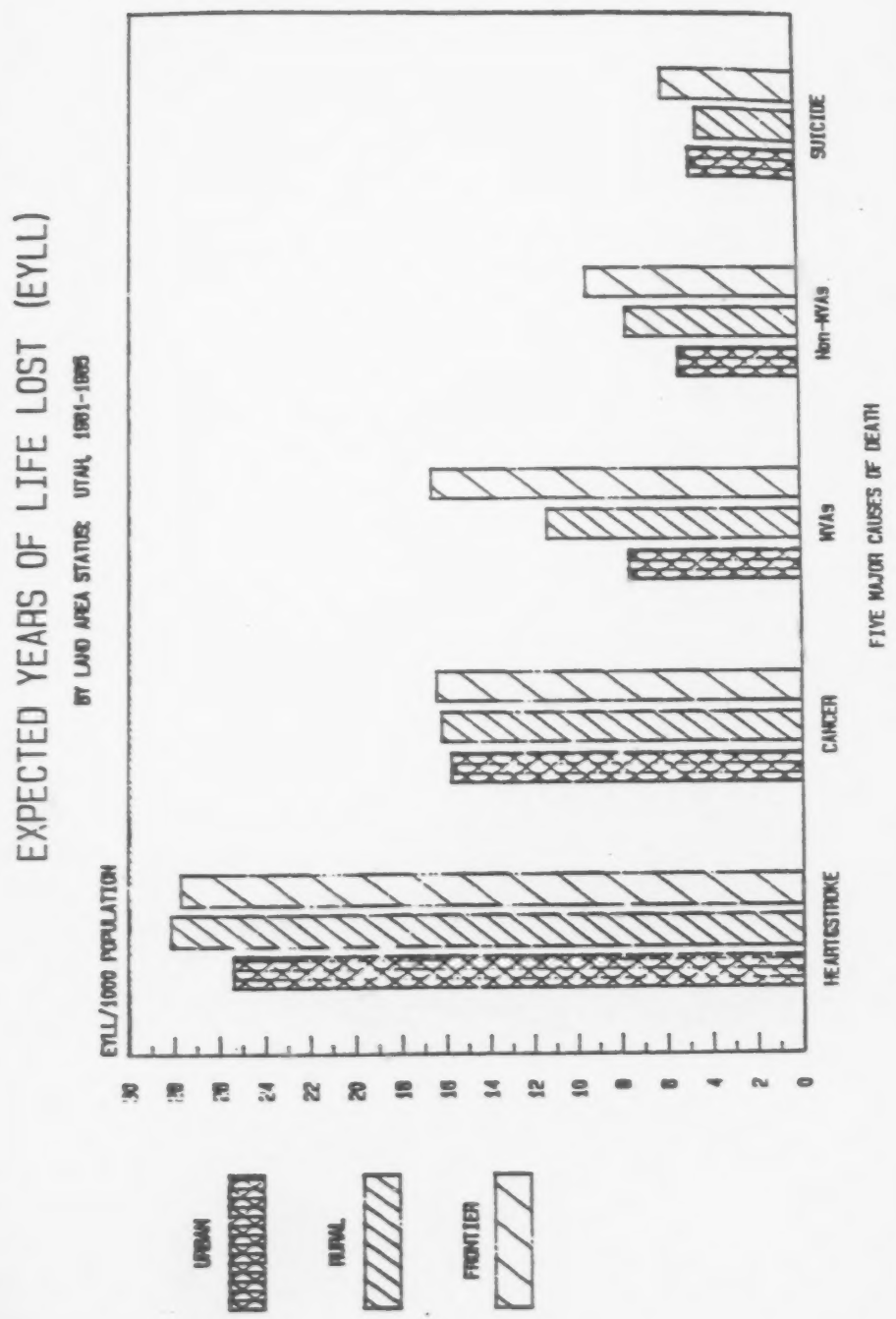
Subpart I of part D of title III (42 U.S.C. 254B et seq.) is amended by adding at the end thereof the following new section:

"SEC. 330A. ADMINISTRATION OF PROGRAMS.

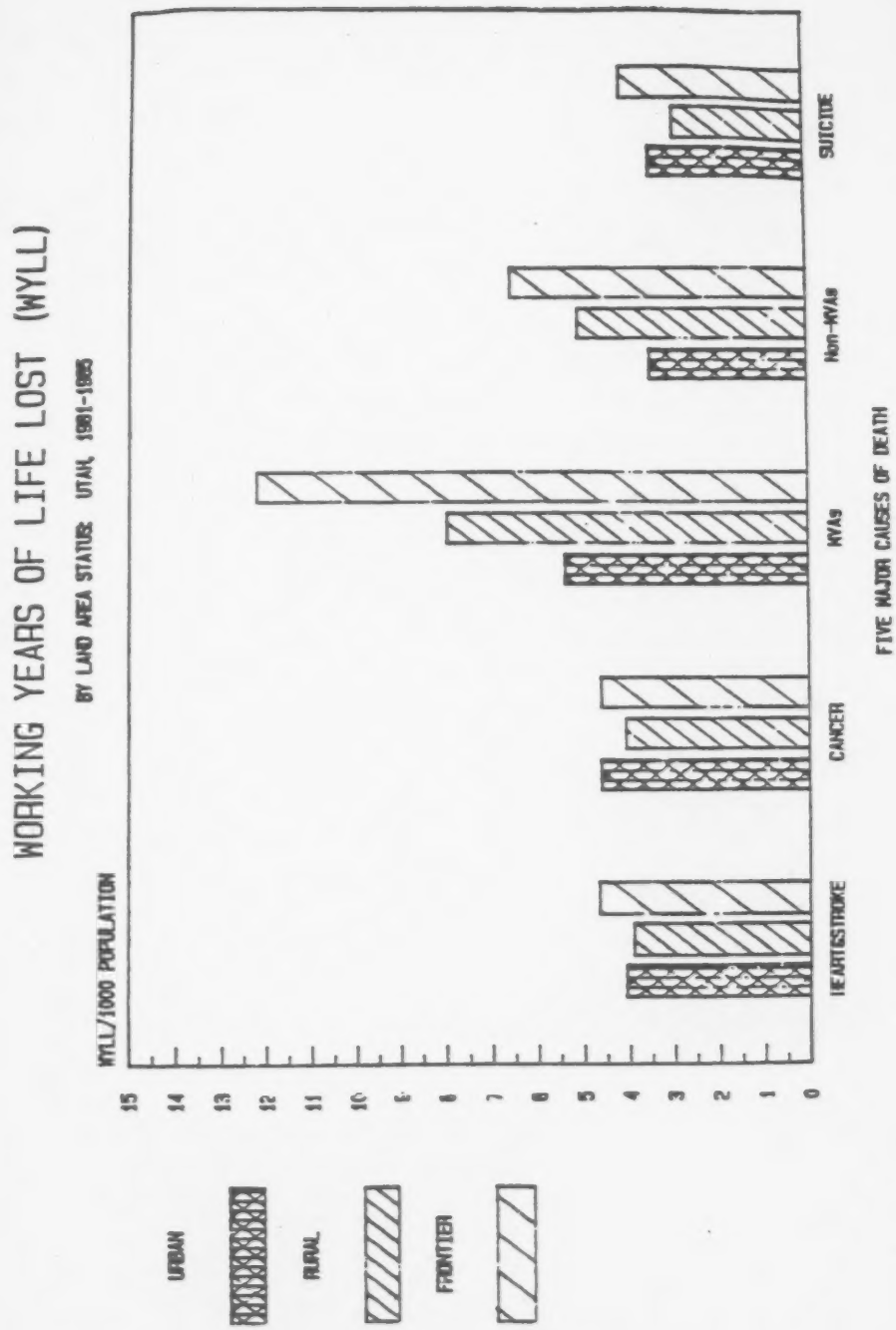
"The Secretary may delegate the authority to administer the programs authorized under section 329 and section 330 to any office within the Public Health Service, except that the authority to enter into, modify, or issue approvals with respect to grants or contracts, may be delegat-

ATTACHMENT J

ATTACHMENT 8



ATTACHMENT 9



ATTACHMENT 1

FRONTIER HEALTH CARE ISSUES

Frontier areas are those that have a population density of less than 6 persons per square mile. Using this as a standard 45% of the United States land area is frontier. Frontier counties are primarily located west of the Mississippi River. Based upon the 1980 Census and on square miles in each county, the percentage of the state that is frontier is shown: Alaska 98%, Arizona 42%, California 17%, Colorado 55%, Idaho 62%, Kansas 29%, Montana 81%, Nebraska 47%, Nevada 84%, New Mexico 52%, North Dakota 61%, Oregon 50%, South Dakota 65%, Texas 30%, Utah 83%, Washington 20%, Wyoming 83%. As these states lack the economic and political muscle of the east and west coast states, their problems tend to be ignored.

Most of the national policies, especially those of the Department of Health and Human Services, exacerbate the very problems they are supposed to alleviate. This is because frontier conditions are different than rural and urban for other parts of the United States. A single set of program guidelines and standards is too rigid for the variety of conditions to be addressed.

The frontier areas have a fragile, usually single industry, economic base. Planning for health services must be tied closely to the economic development plans of the areas in order to be successful.

Health care services are sparse with home health aides and volunteer emergency medical technicians being the primary care providers in many instances. Often even these do not exist. These areas generally meet the federal definitions of "medically underserved and manpower shortage areas."

The hospitals are small usually less than 50 beds and are very vulnerable to economic cycles and staff shortages. Nationally about 220 hospitals are "Frontier Hospitals" and most are sole providers. Many have long term care or swing beds. These facilities are generally owned by a non-profit organization or local government.

Reimbursement policies often have unintended negative consequences upon these facilities. According to ProPac, the hospitals under 50 beds are the ones most severely impacted with DRG reimbursement rates. The reimbursement rates usually do not allow for higher than average costs due to distance and remoteness. Most facilities in frontier areas have higher costs for utilities, supplies, food and labor, than do facilities in rural or urban areas.

Frontier areas have large numbers of elderly with many health problems. Many of the individuals are uninsured or underinsured for health care. At least three studies indicate that individuals who live in these areas have poorer health status than those in the rural and urban areas.

Mortality data indicate that the frontier areas have a higher rate of working years of life lost than do the rural or urban areas for the following leading cause of death: Motor vehicle accidents, diseases of early infancy, non-motor vehicle accidents, heart disease and stroke. Suicide is increasing rapidly in frontier areas.

CONTACTS

LOCAL

UTAH DEPARTMENT OF HEALTH
Bureau of Planning & Policy
P.O. Box 16700
Salt Lake City, Utah 84116-0700
Telephone 801-538-6310

NATIONAL

NATIONAL RURAL HEALTH ASSOCIATION
301 East Armour Blvd., Suite 420
Kansas City, Missouri 64111
Telephone 816-756-3140

ATTACHMENT K

HEALTH STATUS BY PLACE OF RESIDENCE

Bernard Osberg

South Dakota Department of Health
1987

HEALTH STATUS BY PLACE OF RESIDENCE

A number of scholars have suggested that the American frontier still exists today. They state that this "frontier" does not consist of any single region where a line of demarcation exists. Rather, they believe that the frontier has become fragmented, existing principally in counties having less than six residents per square mile.[1]

Although the study of health status by residence is not new, a number of states have recently begun examining health status according to population density. Utah, for example, recently completed a study wherein health status, measured in terms of working years of life lost from leading causes of death,* was compared among three types of geographical areas.[2] These areas were frontier (counties having less than six residents per square mile), rural (counties having between six and 99 persons per square mile), and urban (counties with 100 or more residents per square mile).

Urban, Rural and Frontier Areas in South Dakota

In South Dakota, we are well aware that population has not been distributed evenly on a geographic basis. The map below and Table 1 illustrate that nearly half the counties (32) and nearly 60 percent of the land area in the state are classified as frontier. However, only one in five persons in this state resides in a frontier area.

---

*Working years of life lost is a mortality statistic which compares the relative impact of each death on working years of life, which is defined as the interval between ages 15 to 65. Individuals who die before reaching age 15 are automatically counted at 50 working years of life lost. Those individuals dying between the ages of 15 and 65 are calculated as having lost a number of working years equal to age 65 minus the age at death. All individuals dying at age 65 or above are counted as having no working years of life lost. Hence, causes of death are measured not only by absoluteness but also in terms of intensity as an economic impact on society.

FIGURE 1

FRONTIER, RURAL AND URBAN AREAS/COUNTIES

(1980 Census)

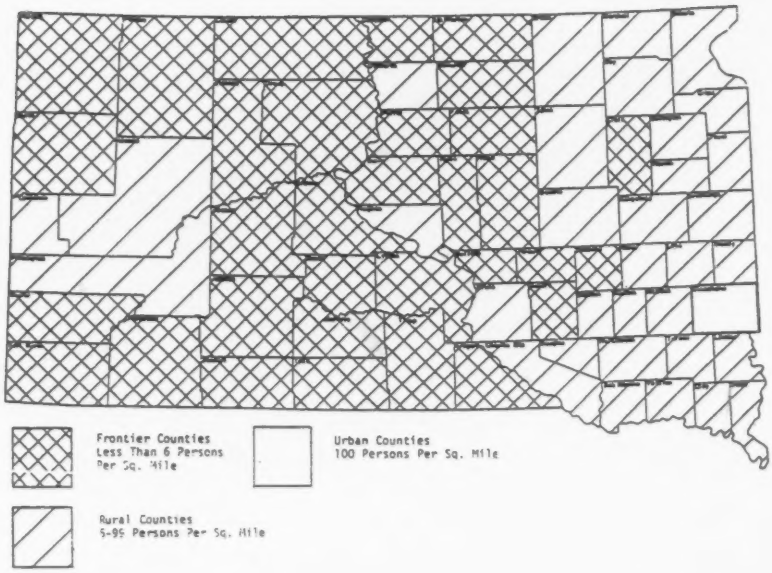


TABLE 1

SIZE AND POPULATION OF FRONTIER, RURAL

AND URBAN AREAS IN SOUTH DAKOTA

1980 Census

Area	Square Miles		1980 Population		Population
	Number	Percent	Number	Percent	Per Sq. Mile
State	75,952	100.0	690,768	100.0	9.1
Frontier Counties	44,914	59.1	137,295	19.9	3.1
Rural Counties	30,228	39.8	444,038	64.3	14.7
Urban Counties	810	1.1	109,435	15.8	135.1

It is interesting to note from Table 1 that most people in South Dakota reside in our definition of rural areas. Rural areas constitute about 40 percent of the land area, but nearly 65 percent of the population.

Finally, as the table and map show, only one region, Minnehaha County, qualifies as an urban area. Minnehaha County averages about 44 times the population density as frontier areas and has a population only 28,000 less than all frontier counties combined.

It has been argued effectively that organized health care services have less effect in determining health status than biological factors, environmental factors or lifestyle.[3] However, access to quality health services does have a positive impact on health. As Table 2 below shows, health services are not distributed evenly across the state.

TABLE 2

SUPPLY OF SELECTED HEALTH PERSONNEL AND FACILITIES IN FRONTIER, RURAL AND URBAN AREAS, JANUARY, 1986

	Frontier		Rural		Urban	
	Number	Percent	Number	Percent	Number	Percent
Number of Physicians	92	9%	554	55%	354	35%
Physicians/1,000 Population	.67		1.25		3.23	
Short Term Care Hospital Beds	757	17%	2,590	58%	1,115	25%
Short Term Care Hospital Beds per 1,000 population	5.51		5.83		10.19	
Nursing Home Beds	1,324	16%	5,957	71%	1,095	13%
Nursing Home Beds per 1,000 population age 65+	76.20		96.00		94.43	

Note: Actively practicing physicians in the employ of the Indian Health Service, Department of Defense, Veterans Administration, and State of South Dakota are counted as well as physicians in private practice. Short term care hospitals include all hospitals which provide general acute care services to the general public or specific segments of the population (e.g. veterans or native Americans). Nursing homes are those licensed by the state.

As to be expected, inequalities exist when one compares the land area of the three categories to the supply of selected health services. However, there are also disparities when one compares populations to the supply of services. For example, frontier areas have a disperately low supply of physicians per 1,000 population. The reasons for this phenomenon are linked to a number of factors, including: ease of travel; difficulty in establishing a practice in frontier areas; low population density; and lack of equipment and trained personnel.

Health Status Indicators for Urban, Rural and Frontier Areas

Table 3 below compares working years of life lost due to selected causes of death among the three areas.

TABLE 3

WORKING YEARS OF LIFE LOST DUE TO SELECTED CAUSES OF DEATH

IN FRONTIER, RURAL, AND URBAN AREAS

	Years of Life Lost Per 1,000 Population		Percent Increase
a. Frontier Areas	1979-81 Avg.	1982-84 Avg.	(Decrease)
1) Motor Vehicle Accidents	56.1	34.8	(38%)
2) Heart Disease & Cardiovascular	29.2	25.1	(14%)
3) All Other Accidents	28.2	25.8	(9%)
4) Cancer	18.4	20.2	10%
5) Conditions...Perinatal Period	15.3	17.1	12%
6) Suicide	13.1	11.1	(15%)
7) Congenital Anomalies	9.7	10.1	4%
b. Rural Areas			
1) Motor Vehicle Accidents	26.3	18.1	(31%)
2) Heart Disease & Cardiovascular	20.6	19.2	(31%)
3) Cancer	20.5	18.9	(8%)
4) All Other Accidents	13.6	13.0	(4%)
5) Conditions...Perinatal Period	12.6	10.2	(19%)
6) Congenital Anomalies	7.9	7.6	(4%)
7) Suicide	7.3	9.1	25%
c. Urban Areas			
1) Cancer	20.5	20.1	(2%)
2) Motor Vehicle Accidents	17.7	13.3	(25%)
3) Conditions...Perinatal Period	16.4	6.9	(58%)
4) Heart Disease & Cardiovascular	15.1	15.9	5%
5) Congenital Anomalies	10.4	9.4	(10%)
6) Suicide	8.7	7.1	(18%)
7) All Other Accidents	8.4	9.0	7%

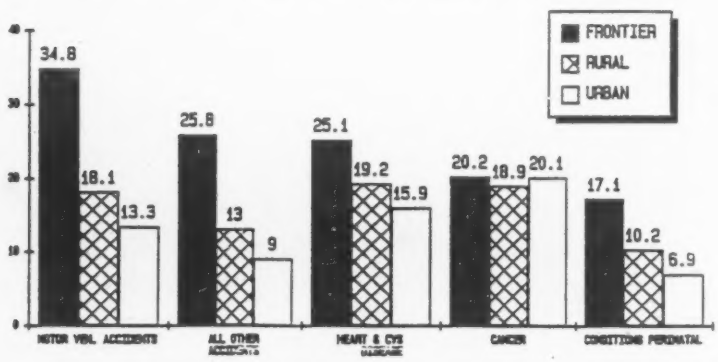
Note: Figures shown are yearly averages for a three-year period. They are not age-adjusted.

Some observations include:

- Motor vehicle accidents is the leading cause of working years of life lost in frontier areas. In rural areas, the pattern has shifted from motor vehicle accidents to heart and cardiovascular disease as the leading cause. In urban areas, cancer remains the leading cause of working years of life lost.
- Decreases in years of life lost due to motor vehicle accidents have been striking in all three areas.
- Frontier areas lose more productive years of life per 1,000 persons than do rural and urban areas. The average years of life lost per year in frontier areas is now about 144 working years per 1,000 residents for selected causes. This compares to 96 working years lost for rural areas and 82 working years lost per 1,000 residents in urban areas.
- The biggest single decrease was in conditions originating in the perinatal period in urban areas (58% decrease). Unfortunately, this was one of the areas of increase in working years of life lost in frontier counties.
- The biggest single increase was in suicide in rural areas (25% increase).

FIGURE 2

COMPARISON OF WORKING YEARS OF LIFE LOST AMONG TOP FIVE CAUSES, 1982-84



FOOTNOTES

[1] Popper, Frank J., Survival of the American Frontier, Resources for the Future, Summer 1984, No. 77, Washington, D.C.

[2] Dandoy, S.; Ellison, F.; and Brockert J., Place of Residence and Health Status, Utah, 1970-1980, February, 1985, Utah Department of Health, Salt Lake City, Utah.

[3] Lalonde, Mark, A New Perspective on the Health of Canadians, Government of Canada, Ottawa, Canada, 1974.

ATTACHMENT L

NRHA Frontier Task Force Calls for Federal Adoption of Designation for "Frontier" Areas

By Carol Miller

In fall 1988, Congress appropriated $15 million to the Health Care Financing Administration (HCFA) for Rural Health Care Transition Grants to aid small (fewer than 100 beds) rural hospitals. Hospitals could apply for $50,000 for two years (maximum of $100,000) to plan and implement programs and services to strengthen their abilities to provide high-quality care to Medicare beneficiaries.

More than 1,100 rural hospitals submitted letters of intent for the funding and HCFA received more than 700 applications. Although HCFA originally intended to fund only 70 to 90 projects, 165 projects were ultimately funded—154 individual hospitals and 11 hospital consortia.

The NRHA Frontier Task Force has analyzed the number of frontier hospitals awarded Rural Health Care Transition Grant funding. Because HCFA has not yet adopted a definition of "frontier," the task force defined frontier as six or fewer people per square mile, the definition determined by the Bureau of Health Care Delivery and Assistance.

When applying that definition of frontier to the 154 hospitals funded, 19 (12 percent) were frontier hospitals. An additional seven hospitals (5 percent) came close to frontier status by having locations in counties of population densities of 6.5 to 7.6 people per square mile. The task force has considered these facilities as frontier in its analysis.

Of the 11 hospital consortia receiving funding, members of four of them were all frontier hospitals. One consortium had both frontier and rural hospitals as members.

One of the goals of the NRHA's Frontier Task Force is encouraging all federal health agencies to adopt a designation for frontier areas. The task force is developing a strategy to expand the frontier designation.

Tremendous gains have been made in recent years to increase public awareness of the special health needs of frontier areas.

For example, many states have designated frontier areas; Congress has requested "special consideration" for frontier areas in Section 330 of Community Health Center funding; the American Public Health Association has adopted a resolution calling for increased access to health programs and services in frontier areas; and the Office of Technology Assessment has included "frontier" in its 1989 publication entitled *Defining Rural Areas: Impact on Health Care Policy and Research.*

The Frontier Task Force invites all NRHA members who live in frontier areas, or are interested in their special needs, to contact Harvey Licht, Chairman, NRHA Frontier Task Force, Primary Care and EMS Bureau, Health and Environment Department, 1190 St. Francis Drive, Santa Fe, N.M. 87503, (505) 827-2527.

Editor's note: Carol Miller is a member of the NRHA Frontier Task Force. She is a public health consultant in Ojo Sarco, N.M.

Health Policy Roundtable Series Now Offered

The NRHA's Health Policy Roundtable teleconference series gives rural health providers and national experts an opportunity to discuss current rural health policy issues.

The 1990 Health Policy Roundtable series includes the following programs.

- **"Treatment Strategies for Cocaine Abuse in Rural Populations,"** Feb. 13, 1990, presented by Catherine Emory, Pharm.D., University of Missouri-Kansas City School of Medicine.
- **"Quality Assurance,"** March 13, 1990, presented by Susan Skelton, R.N., C.C.R.N., Quality Assurance Nurse Specialist, Veterans Administration Medical Center, Kansas City, Mo.
- **"Geriatrics, Accidents, Medication and Depression,"** April 10, 1990, presented by Steven Levenson, M.D., Levindale Geriatric Center, University of Maryland, Baltimore, Md.
- **"Ambulatory Sentinel Practice Network,"** May 8, 1990, presented by Larry A. Green, M.D., Department of Family Medicine, University of Colorado Health Sciences Center, Denver, Colo.
- **"Ethical Issues in Rural Health,"** June 12, 1990, presented by William Nelson, Ph.D., Veterans Administration Medical and Regional Office, White River Junction, Vt.

Teleconference participants telephone the network headquarters and are then linked for the presentations. Each session lasts one hour and includes a formal presentation and a discussion period. Continuing medical education credit is available.

Partial funding for the Health Policy Roundtable teleconference series is provided by the Bureau of Health Care Delivery and Assistance.

For registration information, contact Kelly Privitera at the NRHA, (816) 756-3140.

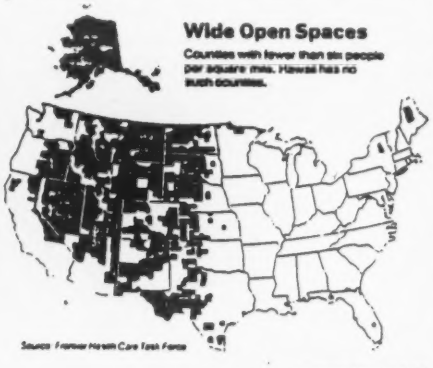
Some Say Frontier Is Still There, and Still Dangerous

By PETER APPLEBOME
Special to The New York Times

AZTEC, N.M. — Nearly a century after experts pronounced the death of the American frontier, a loosely knit group of academics and public officials are arguing that the death sentence was premature. The frontier is still out there in all its harshness, they say, even if its borders are harder to define.

They say the vast open spaces of the West remain the nation's most misunderstood and dangerous region, and one that needs to be viewed in an entirely different light than its rural counterparts elsewhere. Experts say the rates of violent death among youths in the most isolated parts of the West are higher than those in big-city ghettos, and studies show residents of the underpopulated areas that some still label the frontier have worse health conditions and live shorter lives.

Frank J. Popper, chairman of the urban studies department at Rutgers University, said the frontier exists as a distinct region with a view of life that stresses independence, risk-taking and individualism, concepts that remain central to both the American imagination and the direction of the West.


Wide Open Spaces
Counties with fewer than six people per square mile. Hawaii has no such counties.
Source: Frontier Health Care Task Force

The New York Times/Dec. 12, 1983

'Macho and Hell-Raising'

"I think we've taken a giant wrong intellectual turn in thinking the frontier disappeared in 1890 or whatever," said Dr. Popper, whose writings on the survival of the frontier have attracted the attention of health care professionals in particular. "It's not as big as it was, but it's there, and in some ways it's just as violent and just as macho and hell-raising in 1987 and 1447."

Over the past two years health planners have increasingly drawn distinctions between generally rural areas and places that are, in effect, on the edge of civilization. Defining the frontier as areas with no more than six people to the square mile, officials note that distance alone provokes rare problems in law enforcement and health care.

"When I was in Vietnam, a medic was never more than 10 minutes away," said Lieut. R. L. Stockard, who heads the New Mexico state police district that includes this northwestern New Mexico town. "Here you can wait by a wreck on the highway for 45 minutes before help gets there."

But more than distance is involved. The frontier is also defined by the West's boom-and-bust economy and dangerous occupations like mining, forestry and oil drilling. Also at play are less tangible factors: the historic machismo of the West, and the transient nature and fragile economies of many Western towns. Some experts contend the combination has produced a far more rootless, violent world than small towns of rural areas elsewhere.

Less of Land, Few People

"Western towns are more of an aggregate than a community," said Phillip A. May, a sociologist at the University of New Mexico. "There is no cultural cohesion. Westerners basically believe in rugged individualism first and the government second."

To people subscribing to the idea of a continuing frontier, its persistence is as clear as the 1980 census. It showed that 394 counties, covering 45 percent of the land area of the United States, including virtually all of Alaska, have six or fewer people per square mile. In all, 2.2 million people live there.

Over the past two years consideration of these sparsely populated areas has gained increasing attention from health care professionals. Many, including Gar T. Elison, director of Health Planning and Analysis of the Utah Department of Health, have argued for a separate designation in assessing health care needs.

> Violence and individualism endure in the West.

"The West has always suffered by being defined by people in the East," said Mr. Elison, who is chairman of the National Frontier Health Care Task Force. "We're always going to have a problem providing services if the frame of reference for rural areas is West Virginia. Standards that make sense in the East are often irrelevant in the West."

He said population and patient census ratios used in evaluating the need for rural health care programs or clinics inevitably short-changed frontier areas. "It's been a way of saying the have-nots will always remain that way, and we resent that," he said.

Rare Needs in Remote Areas

Mr. Elison said that in the past two years some 15 health care organizations have endorsed the basic concept of having different standards for frontier areas. Similarly, he said, a recent health bill in the House of Representatives cited the need for recognizing the underpopulated regions' different needs.

There have been few definitive studies on differences between such areas and places with 6 to 100 people to the square mile, which would be classified as "rural." But recent analyses of statistics in Idaho, Utah, South Dakota, Nebraska and Wyoming indicate residents in the frontier areas have poorer health than those in urban or rural ones.

Mr. Elison said a study of mortality data in Utah showed frontier residents fared the worst in terms of working years of life lost because of several leading causes of death, including suicide, automobile accidents, other accidents and infant diseases. (Working years are defined as the years from the age of 15 to 65, and the figure is derived by subtracting the age of death from 65.)

The figures are 33.5 percent higher in frontier areas than in urban ones, Mr. Elison said.

Shift in Ideas on Violence

For academics like Dr. Popper, the frontier designation is less a tool for program planning than a window into the sparsely populated areas of the West.

He argues that the obscurity of life in those areas has distorted some of the ideas about violence in the United States.

In a paper in The Public Interest this spring, Dr. Popper and two colleagues analyzed violent deaths for American youths from 1939 through 1979. They studied rates for 15-to-24-year-old whites, including Hispanic people, and found that the Western states invariably had the highest death rates and the Northeast the lowest. In the states with the highest death rates, Arizona, Nevada, New Mexico, and Utah, the most dangerous counties were the less populated ones.

Typically, these counties had higher death rates among their white population than high-crime cities showed for urban blacks, Dr. Popper said.

"The rural areas of the West, rather than the American urban ghetto, is where youth is far more likely to suffer violent death," Dr. Popper and his colleagues, Michael R. Greenberg and George W. Carey, concluded.

Studies in 1966 by the Federal Centers for Disease Control found that the West had the highest rates for youth suicides and for homicides among both whites and blacks. Experts cite as reasons not only dangerous occupations and the individualism of the rural West but also the high number of fatal auto accidents, reflecting both widespread drinking, dangerous roads and the difficulties in providing emergency care in rural areas.

They're on Their Own

Law-enforcement officials say the individualism of the West is reflected in what is often a predilection to handle problems outside the law.

"In a lot of these areas, there's really no law enforcement — no police, no sheriff, no state police station," said Lieutenant Stockard, the state police official here. "People prefer to handle their own affairs and disputes by themselves."

He said the problems are compounded by a disparate ethnic mix. His region includes insular Hispanic communities like Cuba, N.M., in the southern part of the district, Indian reservations with high mortality rates and alcohol problems in the middle, and largely white communities dependent on mining and oil and gas to the north.

Mr. Elison said many Western states were involved in efforts to try to gather data on frontier regions, and there are few definitive studies. But he said most of the available figures probably understated problems there because they did not take into account the economic distress and resultant problems of the past few years throughout the West.

"We're in the midst of an economic crisis that began in 1983 and earlier numbers are not going to reflect it," he said. "You look at the economy of the West, agriculture is down, oil and gas are down, mining is down, forest industries are down, housing starts are down. All those things are going to have an impact."

N. Y. Times
Sat Dec 12

Old frontier faces modern problems

By JERRY TIPPENS
Associate Editor, The Oregonian

The western frontier that was declared closed a century ago has been declared reopened.

It may come as a disappointment to Alaska, which regards itself as the last frontier, that it is now simply grouped with vast areas of 17 other states that constituted the frontier of lore and legend during the 19th century settlement of the West.

TIPPENS

Frank J. Popper, chairman of the urban studies department of Rutgers University, says the frontier never really closed. Defining it as areas containing less than six persons per square mile, he sees it as occupying most of the territory from roughly the Cascades and Sierra Nevada on the west to the 98th meridian on the east.

It is still a rough and tumble territory, he said, marked by dangerous occupations and lifestyles, along with poorer health care and higher accident rates than the rest of the country.

He also would like to evacuate what little population there is in the Great Plains portion of the frontier. The Midwestern style agriculture that was introduced to the Dakotas and Montana down through Texas and New Mexico was a commercial and environmental mistake, in his view, and should be corrected by returning the region to the public domain, with the federal government buying it back if necessary. He would restore its native grasses and give it back to the buffalo and other wildlife that roamed its expanses before the homesteaders came.

There is no question that great agricultural miscalculations were made on the dry and fragile prairies, but an adjustment to less cultivation of the soil and to more responsible grazing practices may ward off depopulation and preserve the delicate environment.

The analysis by a New Jersey academic does bring to mind an observation reported by The New York Times and carried in The Oregonian Dec. 25. "The West has always suffered by being defined by people in the East," said Gar T. Ellison, director of health planning and analysis in the Utah Department of Health. "We're always going to have a problem providing services if the frame of reference for rural areas is West Virginia. Standards that make sense in the East are often irrelevant in the West."

He might have gone a step further and said that the newly found frontier might also have troubles if the definition comes from cities so far west they cease to be Western, in the sense of the frontier culture.

The coastal West from Seattle, through Portland, Salem and Eugene and on down through San Francisco and Los Angeles, was settled differently, has a different history and a different heritage.

The differences prompted a transplanted Coloradan newly arrived in Los Angeles several years ago to comment that he would like to go "back west to Denver."

Part of the problem is that the 48 percent of the country described as the continuing frontier has never had a cohesive regional perspective. Along the western tier of states, the outlook has been shaped by majority populations in Washington, Oregon and California living west of the frontier border.

Along the Eastern tier of states, the Dakotas, Nebraska and Kansas generally have been lumped with the Midwest and Oklahoma and Texas with the South, even though extensive land areas in all of these states would belong in Popper's frontier.

Indeed, in lifestyles, agriculture and social practices, there is little to choose from in rural communities, towns and small cities from the western Dakotas, across Montana, Wyoming and Idaho to Eastern Oregon and Washington. They may have more in common with one another than they do with others in their own states. They have more variety in terrain than in culture.

What the rediscovery of the old frontier may produce is a new focus on what constitutes a western region and its common interests. Then the issues of health care, education, safety practices, resource management and economic considerations could be approached from definitions that are home-grown in "a modern frontier" and not imported from either the East or West.

THE OREGONIAN THURS JAN 31 1985

LETTERS C.6

SEPTEMBER/OCTOBER 1986

SEP 17 1986

RURAL HEALTH CARE

The Newsletter of the National Rural Health Care Association

VOLUME 8, NUMBER 5

Rural Rep Appointed to Physician Payment Panel

Yielding to the pressure of a letter signed by over 30 U.S. Senators, John Gibbons, Director of the Office of Technology Assessment, announced the appointment of Jim Bob Brame, M.D., to the Physician Payment Review Commission (PhysPRC). Dr. Brame, a family physician from Eldorado, Texas, was the nominee of the National Rural Health Care Association and the American Academy of Family Physicians. The appointment of Dr. Brame addresses the two complaints voiced by Senate members of the Rural Health Caucus, i.e., the lack of a rural or a southern representative on the Commission.

NRHCA President Dr. Kevin Fickenscher said he was pleased with the appointment of Dr. Brame. "Dr. Brame's appointment to PhysPRC is a breakthrough for rural health care," Fickenscher said. "I am particularly pleased that he is the joint nominee of NRHCA and the American Academy of Family Physicians."

PhysPRC was created to make recommendations to the Secretary of the Department of Health and Human Services and to Congress regarding payments for physician services. The statute explicitly requires that those recommendations take into account "differences in payment amounts for physician services . . . which are based on differences of geographic location or specialty."

Frontier Areas: Problems for Delivery of Health Care Services

Gar Elison

In 1984, nearly a century after the Census Bureau had declared the frontier settled, a new understanding of America's most rural areas was emerging.

Frank Popper, a demographer at Rutger's University, began to present research from a book in progress called The Survival of the American Frontier. Using a definition of frontier as six or fewer persons per square mile, Popper found that 394 counties and 45% of the United States land area would meet the standard.

On a county basis, Alaska is 96% frontier, Nevada 80%, Utah 55%, Idaho 44%, Montana 41%, New Mexico and Oregon 27%, and Nebraska 24%. Many counties are skewed away from the standard by the presence of a single small city or large town. Eliminating these cities and towns from consideration greatly increases the size of the frontier.

Interest in frontier areas began in 1985 when health care providers in rural areas, public health planning staff, and Health and Human Services (HHS) staff in three regions agreed that frontiers were a unique type of service setting and should be considered under different criteria than those used for rural or urban service areas.

Under sponsorship of HHS Regions VII and VIII, a Frontier Health Care Task Force was convened to look at frontier health issues. The Task Force, in cooperation with the National Rural Health Care Association, has developed distinguishing characteristics that show the differences between frontier, rural, and urban service areas.

The Bureau of Health Care Delivery and Assistance, Department of Health and Human Services, considered these characteristics and has adopted the following general guidelines for approving federal assistance to community health centers in frontier areas:

Service Area: a rational area in the frontier will have at least 500 residents within a 25 mile radius of the health service delivery site or within a logical trade area. Most areas will have between 500–3,000 residents and cover large geographic areas.

Population Density: the service area will have six or fewer persons per square mile.

Distance: the service area will be such that the distance from the primary care site to the next level of care will be more than 45 miles and/or 60 minutes. Next level

continued on page 3

Inside This Issue . . .

SECOND ANNUAL HEALTH POLICY ROUNDTABLE SERIES SOON UNDERWAY
Beginning in November, NRHCA will offer its second teleconferencing policy series for both physicians and administrators. Subjects, presentors, and the schedule of calls are listed on Page 11.

NRHCA CALL FOR PAPERS
Papers and poster session proposals are invited for the Association's tenth annual conference in Nashville. The deadline is December 31, 1986. Guidelines for submissions are found on Page 5.

PARTICIPATION LEVEL WITH HMOs REQUIRES PRE-AFFILIATION SCRUTINY
Marketing, Risk, Patient Management: only three of the basic factors to consider prior to an HMO-affiliation, regardless of it being a fee-for-service arrangement or a joint venture. Physicians, medical groups and clinics will benefit from the 12-point framework provided on Page 10.

RULES AND ETIQUETTE OF LOBBYING
Although one need not be a lawyer to participate in the lobbying process, house counsel ought to be available. This suggestion was one of many provided by the presenters of the conference session, "How To Lobby Effectively at the State Level." Page 7.

Frontier Areas

continued from page 1

of care refers to a hospital with 24-hour emergency room and surgery capability and able to handle an emergency cesarean section or a person with a heart attack. The hospital specialties will generally be pediatrics, obstetrics/gynecology and internal medicine.

Because of the unique nature of frontier areas and the difficulty in developing eligibility criteria which fit all cases, there will be an opportunity for organizations to justify any unusual circumstances which may qualify an area as frontier. Some special considerations may be given for factors such as economics of the area, or unusual geography.

The adoption of these criteria is very important because many of the areas would not qualify for assistance under current criteria. Further, the Bureau of Health Care Delivery and Assistance will use the frontier concept as it revises the regulations governing Medically Underserved Areas.

The National Rural Health Care Association has adopted a resolution acknowledging frontier areas and will encourage research on health status, services delivery and special requirements of these areas. The American Public Health Association also is considering a resolution on frontier areas. In addition, the Frontier Health Care Task Force is sharing information with entities that develop program policy including the National Governor's Association, the National Council of State Legislatures and the National Association of Counties. The objective is to have policy and program guidelines that are compatible with the needs of frontier areas.

NRHCA is submitting a proposal to HHS to fund the Task Force for at least another year. Some items the Task Force will do include:

- develop service delivery standards;
- identify ways to support and stabilize existing providers to prevent further deterioration and loss of service;
- create new service models which make greater use of mid-level practitioners;
- work with foundations to obtain funding for at least two demonstration projects for frontier services delivery;
- develop model legislation which states may use to allow mid-level practitioners authority to function in a broadened role;
- examine expanded use of mail order pharmacies to meet frontier needs;
- identify strategies for working with professional, legislative and administrative bodies so that the unique conditions of frontiers are considered in any policy.

If you have input for the Task Force, you may contact the NRHCA office in Kansas City, or Gar Elson, Utah Department of Health, P.O. Box 16700, Salt Lake City, UT 84116-0700.

DISTINGUISHING CHARACTERISTICS OF SERVICE SETTINGS

PARAMETER	URBAN	RURAL	FRONTIER
Driving time	less than 30 minutes	30 minutes	60 minutes or severe geographic & climatic conditions, especially seasonal
Staffing	Gate Keepers and specialty teams	Generalist, usually a physician with possible assistance from mid-level practitioners	Practitioner teams, mid-level practitioners
Population Density	More than 100/ square mile	More than 6 but less than 100/sq mile	Less than 6 per sq mile
Scale	Large group practice	Small group practice	Part solo or intermittent
Hospital	Large, usually 100 or more beds/facility or satellite	Small 25–100 beds may have swing beds	25 beds or less or no hospital
Technology	High level of technology easy access	Medium level of technology easy to moderate access	Low level of technology difficult access
Skill range of provider	Specialist	Generalist with distinctions specialist consultation	Extreme generalist infrequent specialist consultation
Intensity of practice	High utilization	Moderate utilization	High stamina, capacity
Social Organization	Individual anonymity accepts help readily, greater dependency	Personal group relationships, self-reliant, interdependency accepts help reluctantly	Personal relationships self-reliant, resists seeking help

MINIMUM RECOMMENDED HEALTH SERVICES

POPULATION/ SERVICE AREA	EMS	PRIMARY CARE	SPECIALTY CARE	HOSPITALIZATION
less than 500	First Responder EMT B-P	Intermittent MLP or MD by appointment Satellite/part-time clinic, EMT supervision via telecommunication and written protocol	Referral	Referral
500–900	EMT B-P First Responder network in outlying areas	Full-time MLP or part-time MD arrangement for emergency coverage and EMT supervision	Referral or periodic arrangement in the community	Referral
900–1500	EMT B-P First Responder network	Full-time MD or MLP, or combination full and part-time group practice, emergency coverage and EMT supervision	Referral or periodic arrangement in the community	Referral and infirmary model
1500–4000+	EMT B-P First Responder network	Small group practice—combination of MD and/or MLP, medical specialists (IM/OM, PI, IM, PED or OB, ChM as determined by community need, emergency coverage and EMT supervision	On-site full-time regularly scheduled clinic within primary care practice, or referral	Small community hospital or infirmary referral

DEPARTMENT OF HEALTH & HUMAN SERVICES

United States Public Health
Region VIII

Memorandum

Date: April 27, 1990

RECEIVED MAY 1 1990

From: Director, DHSD, Region VIII

Subject: Request to Review BHCDA Frontier Health Policy Issues

To: Director, DPCS

Noting the upcoming May 16-19, 1990 NRHA meeting in New Orleans, it occurred to me that this might also be a good time to review BHCDA's posture toward the smallest and most isolated segment of the C/MHC community often referred to as "frontier" areas. While we can generally pat ourselves on our collective back for the overall success of the centralized administration of the C/MHC program based on the twin goals of "consistency" and "equity", it appears that this process may also be placing hurdles in the path of many smaller projects that do not have the resources, expertise, "critical mass" etc. to successfully compete with their larger C/MHC cousins. As I'm sure you recall, prior to the centralization movement, several western Regional Offices attempted to surface a variety of issues relevant to the unique circumstances of these projects which in turn led to a succession of meetings, position papers, and guidances. Important key events which occurred during this period of transition are summarized below:

1. Region VIII co-sponsors major Frontier Medicine meeting in Denver during the week of January 30, 1985 (Attachment A).

2. Region VIII helps draft BHCDA Frontier RGM May 9, 1986 (Attachment B).

3. BHCDA issues Primary Care Activities in Frontier Areas RPG 86-10 June 10, 1986 (Attachment C).

4. BHCDA issues "Rural Consortia" guidance to promote economies of scale, cooperative agreements, etc. in rural areas through consolidation strategies between 1985 - 1987 (Attachment D).

5. Section 330 (42 U.S.C. 254c) statute is amended August 10, 1988 requiring BHCDA to give "special consideration to the unique needs of frontier areas" (Attachment E).

6. NRHA "Frontier Study Group" drafts a preliminary analysis and recommendations for BHCDA with respect to structural characteristics and BCRR indicators February 8, 1989 (Attachment F).

7. BHCDA provides special funding to NRHA "Four Corners Project" to enhance R&R activities in frontier areas of Colorado, Utah, New Mexico, and Arizona via FY- 89 CA awards (Attachment G).

8. Region VIII conducts special study of frontier project BCRR data looking at 1987-1989 indicator trends that are inhibiting full compliance with financial performance criteria on BHCDA CE during March 1990 (Attachment H).

Despite all the meetings and words that have been written over the past five years on this subject, it does not appear that the findings and recommendations made by these groups have been included in our centralized evaluation process. As a result, many of this Region's frontier projects feel they are being placed at an unfair disadvantage by the system (at best) and covertly being targeted for phase-out (at worst). Although I have no hard data, I suspect that there may be similar concerns regarding small projects in other western regions. Clearly, the potential loss of access sites for a rural region such as Region VIII could be great unless we find a better way to assist frontier (as well as migrant voucher) projects to cope with the changes that have occurred as a result of our attempts to treat everyone in an "equal" as opposed to "equitable" and consistent manner. Our projects are not "equal" in terms of resources or circumstances. Equitable treatment may, indeed, vary among projects, as the particular situation is considered.

In discussing this issue with knowledgable people at both the community and state levels, there seems to be a growing consensus that perhaps there isn't so much "wrong" with these small projects as with the manner in which federal expectations are currently being applied. Alternatively, it has been frequently suggested that BHCDA can and should modify some of its criteria (as it is applied to frontier sites) in order to accommodate local circumstances and limitations, rather than assuming everyone is a cloned, urban/large rural CHC staff model. The following illustrate some of the questions that have been raised:

ISSUE: 1. Governance: Small projects in large remote areas sometimes find it difficult to gather a quorum to conduct business.

SUGGESTION: Alternate ways of meeting the statutory monthly meeting requirement should be considered, e.g., quarterly board meetings with conferenace calls during the intervening months. Perhaps waivers, consistent with Regulations, of the minimum 9 member requirement should be considered in frontier areas where it is difficult to get people together on a regular monthly basis.

ISSUE: 2. Fiscal Expectations: Expectation that all projects must meet the charge to reimbursable cost indicator at the 90% level.

SUGGESTION: This is an area that Region VIII staff have been reviewing along with our Regional Association. We have not been able to complete a careful analysis, and the "opinions" are varied on this issue. However, the reality of higher than average fixed costs in a smaller operation coupled with lower utilization is an issue which should not be ignored. While the 60% figure suggested in NRHA Study Group's analysis may be too low, the fact that less than half of this Region's frontier projects have ever met this indicator (without shifting costs from the reimbursable to the non-reimbursable costs centers) suggests that the indicator may not be appropriate to measure the performance of very small projects. Perhaps we should take a look at this problem to see if a range of acceptability based on fixed costs might be more appropriate.

ISSUE: 3. Clinical Expectations: While everyone is obviously in favor of high quality health care, current and certainly revised BHCDA expectations call for a multitude of clinical evaluations, including the project's health care plan across all lifecycles, three (documented) peer review audits, plus

semi-annual audits of at least 50 charts for patients in the pediatric, adolescent, adult, and geriatric lifecycles. The impact of performing (and documenting) all these evaluations (in addition to conducting annual health status needs assessments, developing health care plans, maintaining POMR records (not to mention time for actually treating patients) is often overwhelming for small, solo-provider sites.

SUGGESTION: Allowances must be provided for smaller projects that do not have 50 or even 20 patients in the particular catagory. Given our current "checklist" mentality, projects which have not reviewed 20 charts are marked down, regardless of the fact that 20 patient charts may not exist. The new performance measures will exercerbate the problem. The reporting format and the checklists should be modified to insure that reviewers understand that using common sense is OK. We also suggest that as an activity or measure is added, we carefully review current requirements to see if any can be dropped off. Cutting some slack, I believe is the term.

ISSUE: 4. Productivity: Clearly, the minimum annual 4200 off-site encounters per provider FTE expectation (or alternate 1200 - 1500 user standard) is quite reasonable for larger projects under most normal circumstances. However, frontier sites frequently do not have either the critical mass of patients or luxury of "unbundling" services through multiple-visit scheduling to meet the standard without resorting to manipulation of FTE data on the BCRR.

SUGGESTION: The NRHA Study Group suggests the existing productivity expectation either be reduced or alternatively that a different mechanism be employed by BHCDA to measure productivity (eg. RVS, service time per patient, etc.). Perhaps this should be explored further.

ISSUE: 5. Service Area Population v. User Population: Current BHCDA "Program Priorities" require projects to demonstrate that their proportion of users with incomes below the poverty level equal or exceed the proportion of service area population under poverty. Many feel this expectation is both unrealistic and unnecessary in frontier areas (or other areas as well) where the project generally serves a broad cross-section of users who are for the most part the same people as the service area population, thus precluding a significant, measurable difference in poverty levels.

SUGGESTION: Again, some flexibility in application of scoring criteria is needed which enables a reviewer to ignore a NO answer in a situation such as the one described above. If you are the only show in the area, everybody will come, and poverty level becomes less of an issue.

ISSUE: 6. Evening/week-end sessions: BHCDA program priorities call for regular weekly evening or weekend "sessions " of at least three hours. While the intent of this expectation is certainly laudable (eg. to accommodate patient convenience), there is often little or no "demand" for this kind of routine scheduling in frontier areas. Rather the major concern is the availability of unscheduled, emergency services during periods when the center is closed.

SUGGESTION: Revise the expectations to allow for the reality of frontier practice instead of holding centers accountable for standards that do not reflect the character or setting of the practice. Again, our allegance to a Yes-No approach does a diservice to those projects where the correct answer may be NO-BUT. Judgement must be allowed.

While other problems and proposed solutions could be cited here, I hope the point has been made that there remains a need to continue refining our expectations in a way that reflects greater sensitivity to the realities of frontier practice. Despite the relatively small numbers of users, particularly those who fall into BHCDA's "special population" priorities, it would indeed be a shame to preclude many frontier sites from competing on a playing field that in some respects is tilted in favor of multi-provider delivery systems in a larger setting. One of the most serious problems we encounter in rural/frontier areas is the constant battle to simply maintain access to care for persons living in these areas. We feel it is essential to minimize exceptions to the application of "consistent" expectations across the board. However, the goal of "equity" suggests that some exceptions are justified so long as we remain committed to a frontier health strategy, and that we therefore should adapt our expectations accordingly.

The staff in Region VIII stand ready to work with you, the associations, the Office of Rural Health Policy, and whoever else is interested in these issues. If you have questions or comments, please give me a call.

Barbara E. Bailey

Attachments

FRONTIER MEDICINE MEETING

MINUTES

January 30, 1985

Denver, Colorado

The Frontier Medicine Meeting was co-sponsored by Public Health Service Regions VII and VIII in Denver, Colorado, January 30, 1985 at the Regional Office. Participants included Central Office Staff, Regional Office Staff from VI, VII, VIII, IX and X, and representatives of federal and state funded primary care delivery sites.

The purpose of the meeting, as stated in the invitation extended by Mr. Y. S. Rhee, Regional Health Administrator, Region VII, was to bring together those individuals who are most interested in and concerned with health care delivery problems unique to "Frontier" areas and to draw from that group a concensus on what those problems are and suggested approaches to solving them.

Welcome and introductions were made by Dr. Audrey Nora, Regional Health Administrator, Region VIII. Mr. Rhee re-stated the purpose and anticipated outcome of the meeting and then turned the morning session over to Mr. Larry Jeter.

Mr. Jeter reviewed the newspaper article from the Omaha World Herald, by Professor Frank J. Popper of Rutgers University which discussed the Frontier, its resources and survival. The concepts discussed in the article and additional materials of Professor Popper, were shared with the participants. The following key points were made by Mr. Jeter:

- The federal government was the initiating and responsible body for the exploration and development of the frontier.
- There is a generalized perception that the frontier no longer exists, or if it does, it is to such a limited extent as to be of minimal significance. This has resulted in a dichotomous view of American territory as being either rural or urban.
- In fact, nearly 25% of American territory has fewer than two persons per square mile, nearly all of which is west of the 98th meridian, the traditional boundary of the arid west. The contemporary definition of frontier used by the Census Bureau is six people per square mile which nets 45% of the land area of the United States as frontier.
- BHCDA support for primary care services into the frontier in the form of RHI grants and rural consortia are not typically available for lack of "critical mass". NHSC obligees who have been recruited into the frontier appear to have typically served their committment and returned to an urban setting.

- The few federally supported providers and private practicioners are experiencing dramatically increased financial risk in the frontier areas which have extremely fragile, single source economies.

- Traditionally public and private sector support systems to the frontier providers are very costly or non-existent.

From his experience in administering numerous frontier provider systems in various locations, Mr. Jeter feels that there must be some networking approaches that could mee some of the need. His ideas to date, shared in correspondence with the PHS Region VII office, were reviewed. He expressed his genuine concern that something needs to be done to prevent the complete loss of health care in the frontier regions and that a forum such as this may generate strategies for experimenting.

GROUP DISCUSSION

A cluster of three clinics each within 25 miles of the other was highlighted. Weekend coverage and other shared arrangements were in place to ease the demand on the individual providers. This appeared to the group to be a logical "rural consortia", but not typical of the service patterns in the frontier where providers may be separated by up to 150 miles. However, even within this three clinic network, the providers experienced a great deal of professional isolationism. Their continuing medical education is accomplished through the mail.

The joint county program of Nevada's primary care consortium, covering 44,000 square miles, reflected a delivery system that has emerged in the frontier. Eight clinics provide services with physician assistants who receive one day per week of onsite supervision. Physician recruitment, locum tenens, CME,etc. are continuing problems experienced with no inexpensive solution. Discussion suggested that this vehicle has some potential for self-sufficiency.

A provider from Texas pointed out that there are probably "levels" of frontier territory. An analysis of the frontier territory should include distances between providers and the nearest medical facility, as well as the two or six people per square mile. In closing, providers coming to the frontier were told to expect brackish water, high utilities and no twenty four hour coverage.

None of the frontier participants had received support or assistance from state or local professional associations, such as the American Medical Association, American Dental Association or American Hospital Association. Those who had explored potential available resources from these or comparable resources encountered prohibitive consultation costs.

Should a vehicle emerge to support frontier areas, it was pointed out that it should not become duplicative of respective state primary care associations or the National Rural Primary Care Association. Mr. Jeter drew an additional distinction between these associations and the vehicle he envisioned: it would not be an advocacy organization, but a service oriented vehicle, hands-on consulting services. Extensive consultation could also be acquired through a 1-800 telephone number.

One participant felt a "network" of all federal and non-federal health care providers was felt to be a potential "horror". It was suggested that perhaps state primary care associations in the frontier could be directed towards some of the concerns lifted; these Associations are in a position to provide some support to providers. Networking of autonomous health centers would require educating local Boards who view the centers as theirs.

The Arizona Primary Care Association was formed around the mission of self-help and mutual assistance versus advocacy. Technical assistance and consultation is provided by State Association staff as well as organization members in the field. These efforts are managed by Merle Zerkle, Executive Director, and Beth Bladen, Field Coordinator.

Current efforts in southeastern Colorado are underway to consolidate hospital services and expand ambulatory care services via a network of six communities in four counties. Most likely there will be a reduction in the number of hospitals, if the communities opt for the proposal, with the development of regional hospitals and greater availability of ambulatory services within each community. One motivator is the local bed loss to distant urban areas each hospital is experiencing because the community views the local hospital as lacking high-technology diagnosis and treatment capabilities. The financial drain on the respective communities to each support a community hospital has brought them together, much the way school consolidation was initiated 20 years ago. Essentially any movement on this joint effort was suggested to have been from the perspective of developing a viable economic base, in this case resulting in consolidation. Should there emerge some frontier support vehicle, it should consider territory or territories suggested by economic bases.

Surveys suggested that as much as 50% of the primary, secondary and tertiary health care in southeast Colorado was being sought outside that four county area. Some data suggests that the care obtained tended to be for longer (more expensive) hospital stays than when obtained locally.

Discussion of assessing all available resources in the frontier area emerged as a key task. The National Association of Flying Physicians was lifted up as one of probably many unusual frontier oriented resources. It was also suggested that the experience of other counties providing frontier medicine should be researched, as well as the "Winnebago doc-in-a-box-on-wheels" approaches in the USA.

The involvement or support of BHCDA for the development or maintenance of this frontier vehicle, suggested one participant, should be minimal or none at all. Support or investment could come from each frontier representative present at the meeting.

State primary care associations, many of which are organizationally very young, lack the resources as well as scope to adequately provide the support suggested by today's discussion of need in the frontier areas.

Following lunch the facilitator summarized the morning's discussion:

1) There appears to be the need for some type of resources providing a frontier medicine network among primary, secondary and tertiary health providers, institutions, associations, etc.

2) Some services which may be provided by a frontier medicine network are:

   a) Low cost technical assistance program to provide for hands-on maintenance and development of existing practices and facilities. i.e. (1) assistance with formation of linkages with other facilities and providers, (2) restructuring of current organizations to improve effectiveness and efficience. (3) provide assistance in all aspects of practice management and marketing.

   b) Centralized assistance in the recruitment, establishment and retention of medical professionals for these isolated frontier areas, i.e. a recruitment and placement service.

   c) assistance to providers and facilities on the evaluation and purchase of large-ticket items, i.e. x-ray equipment, computer systems, etc.

   d) development of a locum tenens program to provide, (at a rational cost), relief for physicians, or other medical providers, so they may pursue continuing education opportunities, or take a vacation, etc.

   e) In general a place for the isolated rural medical provider or manager to turn when questions or problems arise concerning their practice or facilities (an "800" phone number).

f) Development of resources for the general improvement of the conditions which exist in the provision of health care services in isolated rural areas.

g) Development of services and programs to meet the expressed needs of frontier providers and facilities.

h) Revenue enhancement efforts of currently practicing providers.

i) Joint marketing efforts (skills to do so).

j) Identification of current resources within the geographic area: AHEC, state associations, professional associations, etc.

3) The geographic scope of such a network for such a frontier medicine network should be a comparatively small, clearly defined area. This would permit incubation of the concept and some trial-and-error experience to be accumulated. Some type of business patterns or shared economic base may suggest the territory to be included in the geographic scope. The makeup could be multi-county, multi-state, cross DHHS Regions or any combination thereof.

The summary comments appeared to restate and satisfy most participants perception of the day's discussion. The floor was then opened for strategies to approach the above effort.

A task force of a smaller number was suggested as a vehicle to carry on exploratory discussions, given the difficulty of re-convening and the productivity of such a large group as assembled for this forum.

Voluntary efforts of those represented in this large forum were considered as a way to clarify and research the ideas proposed. Such efforts would include at a minimum the identification of all health resources in the targeted area and a survey of their present needs and perceptions of how a frontier medicine network might support them.

The geographic scope initially selected could serve as a model or pilot for the development of comparable frontier medicine networks, given the development of a single frontier medicine network as impractical.

The large multi-region forum convened today could serve as an ongoing body, collectively and independently sharing information and innovations among themselves and with the task force. Participants felt a re-convening of this large forum would be informative and productive in one year to review and efforts initiated and those in place presently.

Prior to adjournment, a PHS representative from each Region was asked for some indication of what they would like to do now:

Region X: would like to participate on the Task Force and share the concepts of today's meeting with their Regional office staff.

Region IX: would like to participate on the Task Force and share the concepts of today's meeting with their Regional office staff.

Region VI: currently the individual states are working on this problem and not sure at this time how a frontier medicine vehicle would assist them.

Region VII and VIII: very committed to the exploration of the feasibility of such a network and willing to consider joint efforts.

TASK FORCE MEETING

Audrey Nora	Barbara Mendrey
Y. B. Rhee	Amanda Ciccarelli
Lou Templeton	Marlene Sarlo
Barbara Bailey	Larry Jeter
Ray Auker	Jeff Bauer
Bill Marshfield	Howard Lipschultz
Nathan Van Eck	Bill Card, Acting Chairperson

Each RHA reaffirmed their committment to exploring the feasibility of a frontier medicine network on a pilot basis in a geographically limited area. An area suggested was western Kansas, western Nebraska, eastern Colorado, South and North Dakota.

Following a review of the forum's proceedings, some assistance may be available to support a three to four month research effort to conceptualize a pilot feasibility study of the joint Region VII and VIII areas. If such a proposal can be drafted, the review and comment of this Task Force would be encouraged and to some extent supported by respective PHS Regional offices.

Additional comments to the preceedings should be directed to the acting chairperson, who will keep Task Force members periodically informed of progress on the frontier medicine network concept.

PROPOSAL TO INITIATE PLANNING AND FEASABILITY ASSESSMENT
FOR A FRONTIER MEDICINE NETWORK

PROBLEM STATEMENT

- Public and private health care providers in the frontier area are experiencing increasing financial risk in deteriorating local economies usually dependent upon a single industry.

- The geographic distance between providers heightens their sense of professional isolation, exacerbated by the continuing high technology medical advances and these providers' lack of access to tertiary facilities for exposure to these advances.

- Similar providers and health resource facilities in the frontier area are unaware of each others' presence and the potential for networking to enchance their individual situations.

PROPOSED SOLUTION

During the course of this four to six month preplanning effort, staff will review available data and target market profiles of a selected frontier area. In consultation with frontier medicine Task Force members, a refined conceptualization of various approaches to address unique frontier medicine issues will be developed.

METHODOLOGY

From within the frontier territory, a clearly defined geographic area will be selected for the piloting of a network. Upon agreement of the Regional Health Administrators of Region VII and VIII and consulatation with the Task Force members, the targeted market will be profiled. These latter efforts will be to document the specific obstacles to health care in this frontier market, potential recipients and resources.

Jonathan Clinical
Post Office Box 0
Mullen, Nebraska 69152
(308) 546-2000

RECEIVED
FEB 22

February 19, 1985

Mrs. Lou Templeton
Department of Health & Human Services, Region VII
Federal Building - 5th Floor
601 East 12th Street
Kansas City, MO 64106

Dear Mrs. Templeton:

As discussed with you by phone on February 15th, the following is a description of the activities I would pursue and the methodology I would use in the planning and development phase (i.e. a three month period from approximately March 1, 1985 to May 31, 1985) for the establishment of an organization which would provide management support services to target area medical providers and facilities:

First 15-18 working days (March):

(1) Secure appropriate maps of target areas and specify exact counties where services will be offered. Work with staff persons from P.H.S. Regions VII and VIII in making final determinations on the specific counties where services will be offered.

(2) Gather all available data on existing medical facilities and providers, location of HPSA areas, etc. in the target areas.

(3) Meet with key health planning personnel from the State Health Departments and/or Health Systems Agencies serving the target areas to gather as much detailed information as possible regarding the medical facilities, providers, and current conditions and status of health services in the target areas.

Second 15-18 working days (April):

(1) Assemble above data into a descriptive analysis of the status of health care, providers, and facilities in the target area.

(2) Draft a working document to be used by P.H.S. staff members, consultant from Community Health Management Corp., and other interested parties to gather input and comments for a final document.

Last 15-18 working days (May):

(1) With the assistance of consultants from CHMC, prepare final document which would include: precise definition of target area, a description of current conditions in target area, definition of support services to be provided by Frontier Medical Management Assistance Organization, and methods to be used in the establishment of the support organization.

(2) Submit final document to appropriate P.H.S. officials.

In general, the medical management support organization would potentially provide the types of services listed on pages six and seven of the document presented by Mr. Bill Card, summarizing the meetings in Denver on January 29-30, 1985.

Exactly how the services will be delivered to medical providers and facilities will be more clearly defined as a result of the development and planning phase.

Please do not hesitate to contact me if I may provide further information on this matter.

Sincerely yours,

Larry G. Jeter
Administrator

LGJ/kjh

FRONTIER MEDICINE MEETING LIST OF PARTICIPANTS

Central Office

- Elsie Sullivan
  Public Health Analyst
  Parklawn Bldg. Room 7A-55
  5600 Fishers Lane
  Rockville, MD 20857

Region VI

- Mary Lou Lane
- Lois Solari
  Public Health Service
  Division Health Services Delivery
  1200 Main Tower, Suite 1835
  Dallas, TX 75202
  (214) 767-3871

- Larry H. Hooper, M.D.
  Dell City Clinic
  P. O. Box 167
  Dell City, TX 79837
  (915) 964-2860

- Roger Owen
  Dell City Clinic
  P. O. Box 167
  Dell City, TX 79837
  (916) 964-2860

Region VII

- Y. B. Rhee
  Regional Health Administrator
  (816) 374-3291
- Louanah Templeton
  Program Management Consultant
  (816) 374-5296
  601 E. 12th Street
  Kansas City, MO 64106

- Larry Jeter
  Administrator
  Sandhills Clinic
  P. O. Box G
  Mullen, NB 69152
  (308) 546-2217

Region VIII

- Audrey Nora, M.C., MPH
  Regional Health Administrator
  (303) 844-6163

- Barbara Bailey,
  Director,
  Division of Health Services Delivery
  (303) 844-3203

- Stanley Mahoney
  Chief, Program Operation Branch:
  Montana, South Dakota, Utah
  (303) 844-3203

- Robert Heggie
  Chief, Program Operation Branch:
  Colorado, North Dakota, Wyoming
  (303) 844-3203

- Joan Carter
  Regional Program Consultant
  for Community Health Centers
  (303) 844-3203

- David Weir
  RPC Rural Health Initiative
  (303) 844-3203

- Roland Garcia, Ph.D.
  RPC Migrant Health
  (303) 844-3203

- Ernest Ficco
  Social Work Consultant
  (303) 844-3203

- Alan Yamashita
  Pharmacy Consultant
  DHHS, Region VIII
  1961 Stout Street
  Denver, CO 80294
  (303) 844-3203

- Marlene Sarlo
  Project Director
  Northwest South Dakota
  Health Services Corp.
  P. O. Box 577
  Faith, SD 57626
  (605) 967-2644

- Alan Strange
  Yellowstone City/County Health Dept.
  P. O. Box 35033
  Billings, MT 59101
  (406) 246-2757

- Barbara Mendrey
  Medical Director
  Wright's Mesa Medical Service
  Norwood, CO 81433
  (303) 327-4233

- Jeff C. Bauer
  P. O. Box 7
  Hilrose, CO 80733
  (303) 847-3725

Region IX

- Ray Auker,
  Associate Director
  Division of Health Services Delivery
  Room 359 Federal Bldg.
  50 United Nations Plaza
  San Francisco, CA 94102
  (415) 556-6098

- Amanda Cicarelli,
  Director
  Central Nevada Rural Health Consortium
  Box 225
  Babbitt, NV 89415
  (702) 945-3381

Region X

- Bill Marshman
  Regional Program Consultant
  for Community Health Centers
  Arcade Plaza Bulding
  1321 Second Avenue
  Seattle, WA 98101
  (206) 442-0513

- Nathan Van Eck,
  President,
  Oregon Primary Care Association
  Z State Health Planning
  and Development Agency
  3886 Beverly St., N.E., Suite 19
  Salem OR 97305-1389
  (503) 378-4684

Community Health Management Corporation

- William Card
  Project Director
  9933 N. Lawler, Suite 205
  Skokie, IL 60077

- Howard Lipshultz,
  Region VIII Team Leader
  245 Columbine Street, #205
  Denver, CO 80206

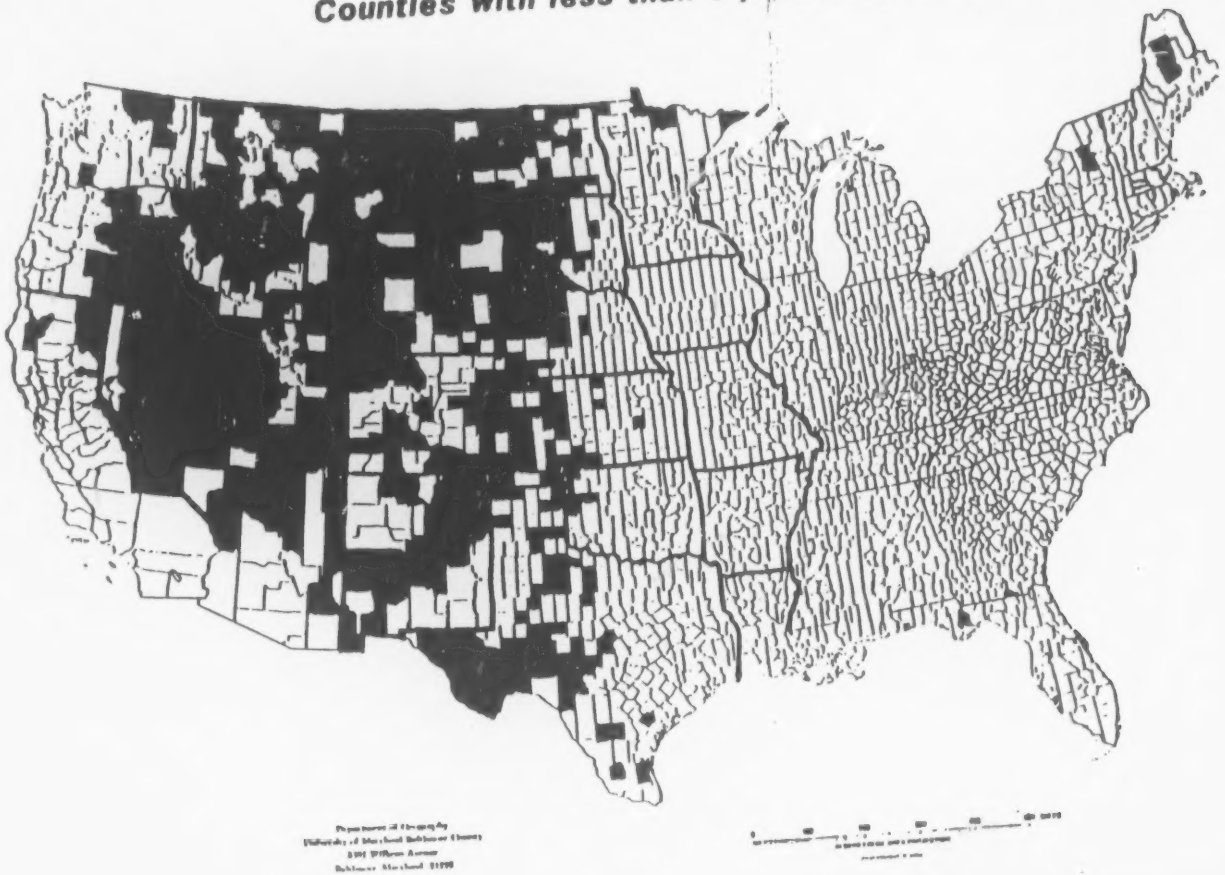
FRONTIER MEDICINE MEETING

JANUARY 30, 1985

DENVER REGIONAL OFFICE
PUBLIC HEALTH SERVICE
1961 Stout Street
Conference Room 1083
Denver, Colorado

9:00.- 9:15....	WELCOME..... "Lone Ranger Day"	Audrey Nora, M.D., MPH RHA, Denver Region VIII
9:15 - 9:30....	Introductions and Overview	Y. B. Rhee RHA Region VII
9:30 -12:00....	Definition of Frontier..... Areas, Statement of Problem and Conceptualizing Possible Solutions	Larry Jeter Administrator Sandhills Clinics
12:00.- 1:30....	L U N C H....	
1:30.- 2:30....	Group Discussion.....	William F. Card Group Facilitator Community Health Management Corporation
2:30 - 3:30....	Development of Action..... Plan.	Larry Jeter
3:30.-4:00.....	Summarization/Wrap-up.....	Bill Card

Counties with less than 6 persons per square miles



FRONTIER HEALTH CARE ISSUES

Frontier areas are those that have a population density of less than 6 persons per square mile. Using this as a standard 45% of the United States land area is frontier. Frontier counties are primarily located west of the Mississippi River. Based upon the 1980 Census and on square miles in each county, the percentage of the state that is frontier is shown: Alaska 98%, Arizona 42%, California 17%, Colorado 55%, Idaho 62%, Kansas 29%, Montana 81%, Nebraska 47%, Nevada 84%, New Mexico 52%, North Dakota 61%, Oregon 50%, South Dakota 65%, Texas 30%, Utah 83%, Washington 20%, Wyoming 83%. As these states lack the economic and political muscle of the east and west coast states, their problems tend to be ignored.

Most of the national policies, especially those of the Department of Health and Human Services, exacerbate the very problems they are supposed to alleviate. This is because frontier conditions are different than rural and urban for other parts of the United States. A single set of program guidelines and standards is too rigid for the variety of conditions to be addressed.

The frontier areas have a fragile, usually single industry, economic base. Planning for health services must be tied closely to the economic development plans of the areas in order to be successful.

Health care services are sparse with home health aides and volunteer emergency medical technicians being the primary care providers in many instances. Often even these do not exist. These areas generally meet the federal definitions of "medically underserved and manpower shortage areas."

The hospitals are small usually less than 50 beds and are very vulnerable to economic cycles and staff shortages. Nationally about 220 hospitals are "Frontier Hospitals" and most are sole providers. Many have long term care or swing beds. These facilities are generally owned by a non-profit organization or local government.

Reimbursement policies often have unintended negative consequences upon these facilities. According to ProPac, the hospitals under 50 beds are the ones most severely impacted with DRG reimbursement rates. The reimbursement rates usually do not allow for higher than average costs due to distance and remoteness. Most facilities in frontier areas have higher costs for utilities, supplies, food and labor, than do facilities in rural or urban areas.

Frontier areas have large numbers of elderly with many health problems. Many of the individuals are uninsured or underinsured for health care. At least three studies indicate that individuals who live in these areas have poorer health status than those in the rural and urban areas.

Mortality data indicate that the frontier areas have a higher rate of working years of life lost than do the rural or urban areas for the following leading cause of death: Motor vehicle accidents, diseases of early infancy, non-motor vehicle accidents, heart disease and stroke. Suicide is increasing rapidly in frontier areas.

CONTACTS

LOCAL

UTAH DEPARTMENT OF HEALTH
Bureau of Planning & Policy
P.O. Box 16700
Salt Lake City, Utah 84116-0700

NATIONAL

NATIONAL RURAL HEALTH ASSOCIATION
301 East Armour Blvd., Suite 420
Kansas City, Missouri 64111
Telephone 816-756-3140

DISTINGUISHING CHARACTERISTICS OF SERVICE SETTINGS

PARAMETER	FRONTIER	RURAL	URBAN
Population Density	Less than 6/per sq mile	More than 6, but less than 100/sq mile	More than 100/ square mile
Driving time	60 minutes or severe geographic & climatic conditions, especially seasonal	30 minutes	less than 30 minutes
Staffing	Practitioner teams, mid-level practitioners	Generalist, usually a physician with possible assistance from mid-level practitioners	Gate Keepers and specialty teams
Scale	Pair, solo, or intermittent	Small group practice	Large group practice
Hospital	25 beds or less, or no hospital	Small 25-100 beds may have swing beds	Large, usually 100 or more beds/facility or satellite
Technology	Low level of technology, difficult access	Medium level of technology, easy to moderate access	High level of technology, easy access
Skill range of provider	Extreme generalist, infrequent specialist consultation	Generalist with distinctions, specialist consultation	Specialist
Intensity of practice	High standby capacity	Moderate utilization	High utilization
Social Organization	Personal relationships, self-reliant, resists seeking help	Personal group relationships, self-reliant, interdependency, accepts help reluntantly	Individual anonymity, accepts help readily, greater dependency

Acting Director

Primary Care Activities in Frontier Areas - Regional Guidance Memorandum

Regional Health Administrators, PHS
Regions I-X

In the course of implementing the Rural Strategy of the Bureau of Health Care Delivery and Assistance, it has become apparent that it is difficult to analyze some number of existing grantees and freestanding National Health Service Corps (NHSC) sites, as well as some areas being considered for capacity expansion, using the same criteria as that used to review rural communities. These grantees/sites/areas are generally characterized as havin a relatively small population base spread over a considerable geographic area. This distinction is important, because the manner in which services ar delivered in these areas which have come to be referred to as "frontier" varies from rural areas having greater population density.

The purpose of this memorandum is to: (1) define frontier areas, (2) establish eligibility criteria for BHCDA support, (3) identify priorities for funding new or continuation applications in frontier areas, and (4) establish a timeline for implementing this policy. It should be noted that any activit related to support for frontier areas must be consistent with the State-based planning efforts on-going in each state and must involve the participation of both the State Health Department the State Primary Care Association to assure coordination of all available resources.

Definition:

For the purpose of this guidance, a "frontier" area shall be defined as follows:

> Frontier areas are those areas located throughout the country which are characterized by a small population base (generally 6 persons per square mile or fewer) which is spread over a considerable geographic area where the forces of topography, water and resource distribution, large federal land holdings, and tribal reservations mitigate against the uniform distribution of population. The primary economic base for these areas is either agriculture, mining, or forestry.

Eligibility Criteria:

To be eligible for BHCDA support as a "frontier" area, the following criteria must be met:

- Service Area: a rational area in the frontier will have at least 500 residents within a 25 mile radius of the health services delivery site. Most areas will have between 500-3,000 residents and cover large geographic areas.
- Population Density: the service area will have six or fewer persons per square mile.
- Distance: the service area will be such that the distance from location within the service area to the next level of care will be more than 45 miles and the average travel time more than 60 minutes. Geographic and/or climatic conditions, which may be seasonal, that affect reasonable access to the next level of care may be factored into this estimate.

Requirement for Funding

Programs serving or proposing to serve frontier areas must meet the legal and regulatory expectations of all Community Health Centers (CHC) programs; however, because of the special nature of frontier areas, the manner in which these expectations are met may differ. All frontier area programs will be assessed to assure that they address the following:

1. Relative demand for services: the determination of the relative neec for services will be based on a consideration of the following:

   - Economic factors affecting the population's access to health services, with emphasis on percentage below poverty, unemployment, and extent of health insurance coverage.

- o Available health resources in relation to the size of the area and its population.
- o Demographic factors affecting the population's need and demand for health services including such factors as seasonal unemployment and/or seasonal variations in population due to proximity to recreational areas.

2. Systems development: program services need to be provided in a manner appropriate to the needs of the service area. Activities in frontier areas should build upon systems of care which are based in or linked to existing programs whenever possible. An effort should be made to use the strengths of existing CHC's. A priority of resource investment in frontier areas will be to stabilize existing systems of care including where appropriate, private as well as public entities. An essential component of the systems development must be the ability to provide for hospitalization.

3. Clinical system: frontier sites must, through staff and supporting resources, or through contracts or cooperative agreements with other public or private entities, provide primary health care services that are available, accessible and assure continuity of care. Essential primary health care services must include physicians or mid-level practitioners who provide diagnosis and treatment, preventive health services, and emergency medical services. Provision must be made for lab, x-ray, and pharmacy services, if not available on site.

4. Governance: frontier applicants must be governed by a board that meets all CHC criteria to assure user involvement in the planning, directing, and allocating of resources. Systems of care such as criteria or networks covering large geographic areas must make additional provision for community participation.

Timeline for Implementation

For the remainder of Fiscal Year 1986 the following activities are necessary:

Existing grantees:

- * utilizing the criteria of this memorandum, regional offices will identify all existing grantees in frontier areas by May 9, 1986.
- * a review of all existing frontier grantees will be completed by regional offices and submitted to Central Office as soon as possible but no later than July 1, 1986. This review sill summarize the five factors of the ZBA process which are examined in the review of any health center with special emphasis on the provision for hospitalization and backup services.
- * Central Office review of frontier programs will be completed and decisions for continuation funding in sequence with project's anniversary dates will be finalized as soon as possible but no later than August 1, 1986.

New Areas of Activity:

As part of the Rural Strategy, a limited number of frontier areas may be identified for primary care capacity expansion or consortia development activities. In Fiscal Year 1986, resources will generally be allocated for planning and developmental activities.

Consistent with the Federal Register notice of February 29, 1986, proposals for new activities in frontier areas will be due in the regional offices by June 1, 1986. Regional offices will submit by July 1, 1986, for each project a 2-3 page summary of their review which includes: documentation of eligibility according to the definitions, a description of the proposed activities, and a determination of the priority for funding using the criteria in this memorandum. Final decisions on the funding of capacity expansion and consortia development proposals will be agreed to by the regional and Central Offices no later than August 15, 1986.

Direct questions and comments regarding this memorandum to Mr. Siege' Young, Branch Chief, Rural Health Branch, DPCS. Mr. Young's telephone number is 443-2220.

Vince L. Hutchins, M.D.

Prepared by:BHCDA/DPCS/RH/Horowitz:efm/4/2/86
Revised by:BHCDA/DPCS/Bohrer:efm/4/17/86
Doc. id 1656d

MINIMUM RECOMMENDED HEALTH SERVICES

opulation/ service area	EMS	Primary Care	Specialty Care	Hospitalization
ess than 500	First responder EMT B-P	Intermittent MLP or MD by appointment Satellite part-time clinic EMT supervision via telecommunication and written protocol	Referral	Referral
00-900	EMT B-P First responder network in outlying areas	Full-time MLP or part MD Arrangement for emergency coverage and EMT supervision	Referral or periodic arrangement in the community	Referral
00-1500	EMT B-P First responder network	Full-time MD or MLP, or combination full and part-time group practice Emergency coverage and EMT supervision	Referral or periodic arrangement in the community	Referral and infirmary model
500-4000+ referral	EMT B-P First responder network ~	Small group practice: combination of MD and/or MLP; medical specialists (MD or MLP); IM, PED or OB, CNM as determined by community need Emergency coverage and EMT supervision	On-site full-time regularly scheduled clinic within primary care practice, or referral	Small community hospital or infirmary,

DISTINGUISHING CHARACTERISTICS OF SERVICE SETTINGS

[illegible]	[illegible]	[illegible]	[illegible]
Driving time	less than 30 minutes	30 minutes	60 minutes or severe geographic and climatic conditions, especially seasonal
Staffing	Gate keepers & specialty teams	Generalist, usually a physician with possible assistance from mid-level practitioners	Practitioner teams, mid-level practitioners
Population density	More than 100/ square mile	More than 6, but less than 100/sq mi	Less than 6/sq mi
Scale	Large group practice	Small group practice	Pair, solo, or intermittent
Hospital	Large, usually 100 or more beds/ facility or satellite	Small 25-100 beds, may have swing beds	25 beds or less, or no hospital
Technology	High level of technology, easy access	Medium level of technology, east to moderate access	Low level of technology difficult access
Skill range of provider	Specialist	Generalist with distinctions, specialist consultation	Extreme generalist, infrequent specialist consultation
Intensity of practice	High utilization	Moderate utilization	High standby capacity
Social organization	Individual anonymity, accepts help readily, greater dependency	Personal group relationships, self-reliant, interdependency, accepts help reluctantly	Personal relationships, self-reliant, resists seeking help

D. Description of services

Each Frontier Health Center will describe the services they provide. This will be developed for each area of the scope of services. The description shall include:

- o type of service
- o how provided (direct, contract, MOU)
- o who provides the service
- o location of the service (on-site, public health office, contract physician, etc.)

If on site: distance and travel time from the health center
reimbursement mechanism
referral system which describes a system for followup and assurance of continuity of care

In addition, the project will describe its plan for capacity building ar systems development/

E. Funding Criteria

The unique environment of the Frontier Health Center requires adaptatior of the funding criteria.

Governance - Depending on the size of the frontier service area and the extent of primary care services, a Frontier Health Center may need a waiver on the number of members of th Governing Board. Five members shall be the minimum number acceptable and all other requirements of governance will remain the same.

Clinical - Frontier Health Centers will have a community-specific clinical arrangement that best meets the needs of the community while accommodating to the realities of the small population and geographic isolation. Many FHC's will not be able to offer a specialty mix of providers on-site. Contractual care and MOU's will occur more frequently in the frontier.

Clinical practice policies will in writing state the center's hours of operation, provision for after-hours coverage, and arrangements for the care of hospitalized patients.

A quality assurance program which provides a health ca: plan, a clinical information system, a periodic assessment, and compliance with BHCDA clinical indicators will be required.

Need/Demand -

a. definition of the service area
b. description of the patient population
c. analysis of the demand for primary care services
d. a description of the resources in the service area and the contiguous areas
e. identification of any special health status needs

Financial management - There is no exception to the financial management criteria for FHC's.

Administration - FHC's with fewer than 2.0 FTE medical providers should not have a full-time project director. In many cases, the provider will also fulfill the administrative functions. Because of small size, administrative overhead may exceed 16% of the health care cost.

BCRR - All Frontier Health Center's should attempt to meet all BCRR indicators. Many will be able to do this with little difficulty. A waiver mechanism can be implemented by center's who can not comply with the indicators. Justification for a waiver should document specific reasons for the inability to comply.

Experience will provide more information on what areas will be most difficult to comply with. The number of encounters/provider may be the hardest to fulfill. The provision of emergency coverage and the amount of time spent in emergency management is not adequately reflected by the number of encounters.

Carol Horowitz

Doc. id 1656d

DEPARTMENT OF HEALTH & HUMAN SERVICES
HEALTH RESOURCES AND SERVICES ADMINISTRATION
BUREAU OF HEALTH CARE DELIVERY AND ASSISTANCE

DHSD JUN 16 '86
Public Health Service

Memorandum

Date JUN 10 1986

From Acting Director

Subject Primary Care Activities in Frontier Areas - Regional Program Guidance Memorandum 86 - 10

To Regional Health Administrators, PHS
Regions I-X

In the course of implementing the Rural Strategy of the Bureau of Health Care Delivery and Assistance (BHCDA), it has become apparent that it is difficult to analyze some number of existing grantees and freestanding National Health Service Corps (NHSC) sites, as well as some areas being considered for capacity expansion, using the same criteria as that used to review rural areas in general. These grantees/sites/areas are generally characterized as having a relatively small population base spread over a considerable geographic area. This distinction is important, because the manner in which services are delivered in these areas which have come to be referred to as "frontier," varies from rural areas having greater population density.

The purpose of this memorandum is to: (1) define frontier areas, (2) establish eligibility criteria for BHCDA support, (3) identify priorities for funding new or continuation applications in frontier areas, and (4) establish a timeline for implementing this policy. It should be noted that any activity related to support for frontier areas must be consistent with the State-based planning efforts ongoing in each State and must involve the participation of the State Health Department and the State Primary Care Association, as well as other appropriate State based agencies, to assure coordination of all available resources.

Definitions:

For the purpose of this guidance, a "frontier" area shall be defined as follows:

- Frontier areas are those areas located throughout the country which are characterized by a small population base (generally six persons per square mile or fewer) which is spread over a considerable geographic area.

Eligibility Criteria:

To be eligible for BHCDA primary care support as a "frontier" area, the following criteria must be met:

- Service Area: a rational area in the frontier will have at least 500 residents within a 25-mile radius of the health services delivery site or within the rationally established trade area. Most areas will have between 500-3,000 residents and cover large geographic areas.

- Population Density: the service area will have six or fewer persons per square mile.

- Distance: the service area will be such that the distance from a primary care delivery site within the service area to the next level of care will be more than 45 miles and/or the average travel time more than 60 minutes. When defining the "next level of care," we are referring to a facility with 24-hour emergency care, with 24-hour capability to handle an emergency Cesarean section or a patient having a heart attack and some specialty mix to include at a minimum, obstetrics, pediatrics, internal medicine, and anesthesia services.

Because of the unique nature of frontier areas and the difficulty in developing eligibility criteria which fit all cases, there will be an opportunity for organizations to justify any unusual circumstances which may qualify them as frontier, for example, geography, exceptional economic conditions, or special health needs.

Priorities for Funding:

Programs serving or proposing to serve frontier areas must meet the legal and regulatory expectations of all Community Health Centers (CHC) programs; however, because of the special nature of frontier areas, the manner in which these expectations are met may differ. All frontier area programs will be assessed to assure that they address the following:

1. Relative demand for services: the determination of the relative need for services will be based on a consideration of the following:

   - o Economic factors affecting the population's access to health services, with emphasis on percentage below poverty, unemployment, and extent of health insurance coverage.
   - o Available health resources in relation to the size of the area and its population.
   - o Demographic factors affecting the population's need and demand for health services including such factors as seasonal unemployment and/or seasonal variations in population.

2. Systems development: program services need to be provided in a manner appropriate to the needs of the service area. Activities in frontier areas should build upon systems of care which are based in or linked to existing programs whenever possible. An effort should be made to use the strengths of existing CHC's. A priority of resource investment in frontier areas will be to stabilize existing systems of care including, where appropriate, private as well as public entities. An essential component of the systems development must be the ability to arrange for inpatient services at the appropriate level of care. Inclement weather will be considered as a design factor for a programmatic response rather than a reason for a year-round project.

3. Clinical system: frontier sites must, through staff and supporting resources, or through contracts or cooperative agreements with other public or private entities, provide primary health care services that are available, accessible and assure continuity of care. Essential primary health care services must include physicians or mid-level practitioners who provide diagnosis and treatment, preventive health services, and emergency medical services. Primary care in these areas should include the capability to stabilize patients for transport to more advanced levels of care. Provision must be made for lab, x-ray, and pharmacy services, if not available on site.

4. Governance: frontier applicants must be governed by a board that meets all CHC criteria to assure user involvement in the planning, directing, and allocating of resources. Systems of care such as consortia or networks covering large geographic areas must make alternative provisions for community participation.

Timeline for Implementation:

For the remainder of Fiscal Year 1986, the following activities are necessary:

Existing grantees:

- utilizing the criteria of this memorandum, regional offices will identify all existing grantees in frontier areas by June 13, 1986.

- a review of all existing frontier grantees will be completed by regional offices and submitted to Central Office as soon as possible but no later than July 1, 1986. This review will summarize the results of each of the elements under Priorities for Funding described above, as well as the results of the ZBA analysis. A map of the service area and contiguous areas will be included. This map will describe the size of the service area (number of square miles), the population density of the service area, and show the location and highway distance to the next level of care as described in this policy.

- Central Office review of frontier programs will be completed and decisions for continuation funding in sequence with project's anniversary dates will be finalized as soon as possible but no later than August 1, 1986.

New Areas of Activity:

- As part of the Rural Strategy, a limited number of frontier areas may be identified for primary care capacity expansion or consortia development activities. In Fiscal Year 1986, resources will generally be allocated for planning and developmental activities.

- Consistent with the Federal Register notice of February 28, 1986, proposals for new activities in frontier areas will be due in the regional offices by June 1, 1986. Regional offices will submit by July 1, 1986, a 2-3 page summary, for each project, of their review which includes: documentation of eligibility according to the definitions, a description of the proposed activities, a map of the proposed service area as described above, and a determination of the priority for funding using the criteria in this memorandum. Final decisions on the funding or capacity expansion and consortia development proposals will be agreed to by the regional and Central Offices no later than August 15, 1986.

Any questions regarding this memorandum should directed to Mr. Siegel Young, Chief, Rural Health Branch, Division of Primary Care Services. Mr. Young's telephone number is 443-2220.

Vince L. Hutchins, M.D.

Federal Rural Strategy

(D)

Betty King, M.P.H., Assistant Director, NRHCA

Our health care lexicon is filled with jargon from current and past Federal initiatives -- words and phrases such as "comprehensive health planning," "HP/DP," "self-sufficiency," "outliers," and yes, even "competition." These terms quickly become hackneyed through overuse--cliches in their own times.

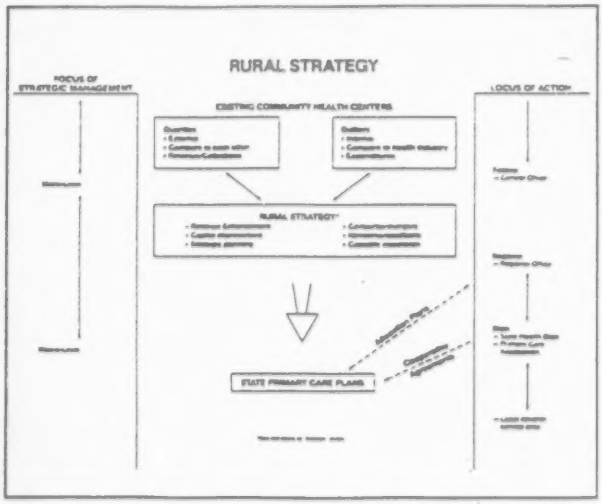
It would be easy to cast the Bureau of Health Care Delivery and Assistance's "rural consortia" in the same role as just another federal initiative to be acted upon quickly and just as quickly forgotten. But to do so would be a mistake, because "rural consortia" are part of an overall BHCDA Rural Strategy. The purpose of this article is to review the consortium concept and more importantly to place it in the context of the changing health environment.

Small practices are at risk in America. Like the mom and pop grocery, small practices may soon be devoured or made irrelevant by other models of care. In order to be competitive, rural practices must begin to form into units which capitalize on the strengths of larger groups, i.e., lower cost due to economies of scale, more comprehensive service packages, ability to bid for contract care and share risk with others; and collegial support arrangements.

Consortia have been defined as "...coalitions of public and private providers whereby individual sites are linked together to create larger, more organized delivery systems than any site could provide on its own."

Consortia building is but one component of the BHCDA Rural Strategy, the goal of which is to ensure the continued delivery of essential medical services to residents of rural America who currently receive care from solo or relatively small groups of public and private practitioners.

Recognizing that rural areas often are characterized by small practices and fewer actual users than their urban counterparts, BHCDA hopes to provide financial, staffing and/or technical resources to assist rural community clinics to develop coordinated multispecialty delivery systems which provide stable and continuing support for rural practitioners and their clinic users. Approximately four million dollars are planned for rural consortia activity during FY 1985 to support 20 consortia started in FY 1984, and to fund 100-120 new consortia during 1985.



Putting the Pieces Together

As shown in the diagram, consortia, as part of the rural strategy, are new approaches based on analysis at the clinic

level as well as at the state level.

Quartiles and outliers are analytical tools developed to show operational aspects for individual health centers through comparison among both other centers and larger health care arena. Quartiles reflect changes outside while outliers look at administratively determined clinic expenditure patterns.

Quartiles are intended to provide a methodology to allow for comparison of individual health center performance relative to other similar health centers. Quartiles emphasize the ability of health centers to maximize revenue and the ability of health center boards and staff to strengthen responsive management, especially in the financial area.

Outliers, another tool to assist in the process of assessing health center performance, are a series of financial and administrative data elements which compare individual health center operations to a series of norms achieved by other public and private health delivery systems.

Outliers seek to focus attention on three distinct features of health services delivery: 1. Critical mass of providers; 2. Cost-competitive medical services; and 3. Essential health services.

With a better understanding of strengths and weaknesses, rural clinics will be in a better position to make difficult decisions. Options may range from networks/coalitions to consortia/mergers. New arrangements may necessitate: 1) strategic planning to comprehensively evaluate alternative services/arrangements; 2) adding physicians with additional medical specialties; 3) expanding or improving health facilities; and/or 4) participating in new reimbursement and financing opportunities, such as capitated Medicaid.

Consortia and other approaches to improving rural (and urban) health care delivery will feed into a comprehensive state level plan. The emphasis on state primary care plans reflects the growing shift of focus to state health departments and primary care associations in identifying both urban and rural health needs.

Rural Consortia: "Who, What, and How"

Consortia may include community health centers, National Health Service Corps sites, private practices, state/county health department and hospitals. Organization around back-up hospital facilities is an essential component.

Shared activities may include clinical services; financial and administrative management; ancillary programs; or joint purchasing.

Available resources to strengthen rural practice may include:

1) Section 329/330 resources
   --Rural consortia
   --New starts
   --Shared services
   --Strategic planning
   --Project enhancement
   --Conversion/base support

2) Other Federal support
   --National Health Service Corps
   --Maternal and Child Health
   --Community development funds

3) Non-Federal resources
   --Foundations
   --State primary care support

Frontier Areas

In its policy memos, BHCDA has recognized that some areas may be so isolated that different approaches are required. It is important in each state to identify those areas where the Rural Strategy will not be feasible because of geographic distances and low population densities.

continued p.6

Conclusion

The entire health care system is undergoing rapid, dramatic changes. The Rural Strategy developed by BHCDA represents a proactive attempt to assure viability of rural health centers by analyzing their current operating characteristics and positioning them to respond to changes in physician supply; finance and reimbursement; and the role of government. Recent AMA survey research indicates that between 1969-1980, the number of physicians in group practice more than doubled, and the number of group practices increased by 70%, with 35% of all groups multispecialty. BHCDA's rural strategy can help small centers form into economic and practice units which emulate larger group practices--they can become extended group practices.

Rural centers must respond to these changes. A slower pace would be preferable, especially a pace which allows for greater process. But stronger systems of care and management, including thorough knowledge of costs and revenues, appropriate staffing, and a sense of where your operation fits in the larger health care context of your area/state are critical for survival.

Only by becoming part of larger coalitions will rural health centers, providers and hospitals avoid the fate of other rural industries, such as the now disappearing "mom and pop store" and family farm. O

NRHCA Rural Strategy Resource Packet

In order to assist with developing consortia, NRHCA has developed a rural strategy resource packet. The packet contains the above article, sample consortia projects, a proposed format, and listing of resource contacts by region. Contact: NRHCA, 2220 Holmes, Kansas City, MO 64108 (816-421-3075).

[Reprinted (condensed) by permission, the Newsletter of the National Rural

"The Secretary may modify the criteria established in regulations issued under this paragraph only after affording public notice and an opportunity for comment on any such proposed modifications".

(d) REQUIREMENT OF FEES CONSISTENT WITH LOCALLY PREVAILING RATES.—Section 330(e)(1)(F)(i) (42 U.S.C. 254c(e)(1)(F)(i)) is amended—

(1) by inserting after "provision of its services" the following: "consistent with locally prevailing rates or charges and"; and

(2) by inserting "has prepared" after "operation and".

(e) AUTHORITY WITH RESPECT TO EXPANSION AND CONSTRUCTION OF CENTERS.—

(1) Section 330 (42 U.S.C. 254c) is amended—

(A) in the second sentence of subsection (e)(1), by striking "acquisition and modernization of existing buildings" and inserting "acquisition, expansion, and modernization of existing buildings and construction of new buildings",

(B) in the matter after and below subsection (d)(1)(C)(iii), by striking "acquisition and modernization of existing buildings" and inserting "acquisition, expansion, and modernization of existing buildings, construction of new buildings,",

(C) in subsection (d)(2), by striking "acquiring and modernizing existing buildings" and inserting "acquiring, expanding, and modernizing existing buildings and constructing new buildings", and

(D) in subsection (d)(1)(B)(ii)(III), by striking "construct and modernize" and inserting "construct, expand, and modernize".

(2) Section 330(e) (42 U.S.C. 254c(e)) is amended by adding at the end the following:

"(6) The Secretary may make a grant under subsection (e) or (d) for the construction of new buildings for a community health center only if the Secretary determines that appropriate facilities are not available through acquiring, modernizing, or expanding existing buildings and that the entity to which the grant will be made has made reasonable efforts to secure from other sources funds, in lieu of the grant, to construct such facilities".

(f) AMOUNT OF GRANTS FOR COSTS OF OPERATION.—

(1) Section 330(d)(4)(A)(i) (42 U.S.C. 254c(d)(4)(A)(i)) is amended to read as follows:

"(i) State, local, and other operational funding; and"

(2) Section 330(d)(4)(B) (42 U.S.C. 254c(d)(4)(B)) is amended by striking out "may retain such an amount (equal to (or less than one-half of the amount by which such sum exceeds) such costs) as the center can demonstrate to the satisfaction of the Secretary will be used to enable the center" in the matter immediately following clause (ii) and inserting in lieu thereof "shall be entitled to retain the additional amount of fees, premiums, and other third party reimbursements as the center will use".

(g) ADMINISTRATION OF PROGRAMS.—Section 330 (42 U.S.C. 254c) is amended by adding at the end the following:

"(j) The Secretary may delegate the authority to administer the programs authorized by this section to any office within the Service, except that the authority to enter into, modify, or issue approvals with respect to grants or contracts may be delegated only within the central office of the Health Resources [illegible]

(b) AUTHORIZATION OF APPROPRIATIONS.—Section 330(g) (42 U.S.C. 254c(g)) is amended— Grants

(1) by amending paragraph (1) to read as follows:

"(1)(A) For the purpose of payments under grants under this section, there are authorized to be appropriated $440,000,000 for fiscal year 1989 and such sums as may be necessary for fiscal years 1990 and 1991.".

~~(2)(A)~~ by redesignating subparagraphs (A) and (B) of paragraph (2) as clauses (i) and (ii), respectively;

(B) by redesignating paragraph (2) as subparagraph (B);

(C) in paragraph (1)(B)(i) (as so redesignated), by striking "this section" and inserting "paragraph (1)"; and

(D) in paragraph (1)(B)(ii) (as so redesignated), by striking "this section" and inserting "paragraph (1)"; and

(3) by inserting after paragraph (1) the following new paragraph:

"(2)(A) For the purpose of carrying out subparagraph (B), there are authorized to be appropriated $25,000,000 for fiscal year 1989, $30,000,000 for fiscal year 1990, and $35,000,000 for fiscal year 1991.

"(B) The Secretary may make grants to community health centers to assist such centers in— Children and youth

"(i) providing services for the reduction of the incidence of infant mortality, and

"(ii) developing and coordinating referral arrangements between community health centers and other entities for the health management of infants and pregnant women. Women

"(C) In making grants under subparagraph (B), the Secretary shall give priority to community health centers providing services to any medically underserved population among which there is a substantial incidence of infant mortality or among which there is a significant increase in the incidence of infant mortality." Disadvantaged persons Children and youth

SEC. 4. REQUIREMENT WITH RESPECT TO FRONTIER AREAS.

Section 330 (42 U.S.C. 254c) is amended by adding at the end the following new subsection:

"(j) In making grants under this section, the Secretary shall give special consideration to the unique needs of frontier areas." Grants

SEC. 5. EFFECTIVE DATE. 42 USC 254c note

The amendments made by this Act shall take effect October 1, 1988, or upon the date of the enactment of this Act, whichever occurs later.

Approved August 10, 1988.

LEGISLATIVE HISTORY—S. 2085 (H.R. 4509):

HOUSE REPORTS: No. 100-719 accompanying H.R. 4509 (Comm. on Energy and Commerce).
SENATE REPORTS: No. 100-311 (Comm. on Labor and Human Resources).
CONGRESSIONAL RECORD, Vol. 134 (1988):
June 13, considered and passed Senate.
June 27, 28, H.R. 4509 considered and passed House.
July 27, [illegible]

PCIS MAR 16 1990

New Mexico Health and Environment Department

CARL A. L. HUT
MICHAEL J. BUEK
ROY D. MERSA

February 8, 1989

To: Amanda Ceccarelli, National Rural Health Association
Dave Roddy, Southwest Primary Care Assocation

From: Kim Kinsey, NM Health and Environment Department
Harvey Licht, NM Health and Environment Department

Subject: Preliminary Analysis by Frontier Study Group

Attached please find a draft report discussing the results of our study of frontier health centers in five western states. It may prove useful to your meeting on new BCRR indicator standards.

In the report we rgue for special standards to be used for frontier clinics. It is our belief that circumstances in frontier areas lead to a different practice profile than is seen in other areas. Adoption of a single set of BCRR standards for both frontier and non-frontier areas could lead to broad-range standards which are virtually meaningless. Separate standards for different classes of health centers would help clarify what could reasonably be expected from each class.

Please let us know your thoughts on the matter.

cc: Robert Van Hook
Gar Elison
Denise Denton
Lindy Wallace
Alison Hughes
Max Chilcott

DRAFT
2/7/89

Frontier Performance Analysis

A. Overview

The Frontier Study Group is completing a survey of BCRR indicators in a five state region of the western United States. BCRR data for three years (1985-7) was collected for all frontier community/migrant health centers and freestanding National Health Service Corps sites in Arizona, Colorado, Nevada, New Mexico, and Utah. Performance of these sites on five main indicators was analyzed:

- Medical Cost per Encounter
- Team Productivity
- Administrative Cost
- Charges as a Percent of Reimburseable Cost, and
- Collections as a Percent of Charges.

A summary of the data for these indicators is presented in an accompanying chart.

Frontier sites appear to have problems complying with at least four of the five indicators. Interestingly, the collections indicator was not a significant problem. This may reflect the cash basis of business in many frontier areas.

The Study Group identified possible reasons for the compliance problems, and developed recommendations for more appropriate standards to be applied to frontier clinics. The results of this analysis is presented below.

B. Identification of Emergent Factors in Frontier Areas

1. Utilization Patterns of Frontier Areas

a) Small Populations:

With relatively small catchment area populations for single clinics, the total potential utilization from the population will be relatively low. For example, a user population of 1200 people, averaging 2.5 visits each, would be able to generate only 3000 visits per year. If a physician were to be located at such a clinic, productivity would fall below the current minimum standards. Standards should recognize that solo or duo practices in frontier areas need either a productivity measure other than number of visits per year or a modified visit/year standard.

b) Extended Service per Visit:

Patients in frontier clinics often average fewer visits per year, but have visits of longer average duration. This may be a reflection of typical demand where patients have lengthy travel time to reach health services. A typical patient will receive several different services on a single visit. In solo or duo practices, these different services will be provided by a single provider. Under current BCRR procedures, only the first service is counted. There is no way to measure the length of service provided to a single patient. This masks to true productivity at a frontier site.

2. Relatively High Fixed Cost in Frontier Areas

Solo and duo practices in frontier areas have a relatively high level of fixed costs when compared to practices with larger numbers of providers. The absolute cost is low, however, the minimum necessary facility, equipment, and personnel costs comprise a more substantial percentage of the total budget.

The relatively high fixed costs lead to problems with several of the BCRR indicator standards. The cost per medical encounter, charges as a percent of costs, and administrative cost percentage all can be pushed beyond the current acceptable limits.

3. Staffing Patterns Necessary in Frontier Areas

a) Frontier practices are often solo or duo practices, i.e. practices where one or two providers perform the entire range of services for patients. This may lead to physicians and mid-levels performing many of the duties typically handled by auxiliary staff (nursing staff, laboratory staff, x-ray technicians, pharmacy staff, etc.) in larger practices. Given the current method of measuring productivity, these efforts of provider staff go uncounted, lowering apparent productivity and raising the cost per encounter. In addition, the use of more expensive staff members to perform routine duties may increase the relative costs of operation.

b) Provider Staffing Patterns:

Staffing of frontier clinics falls into two major patterns:

Resident provider: where a provider is recruited to live and work in a frontier community. This allows the physician or mid-level provider to be available full-time and after-hours.

Circuit riding provider: where provider staff travel to frontier clinic locations but reside in other communities. This often leads to part-time clinic schedules (care is delivered only when a physician or mid-level provider is on-site) and limited after-hours coverage.

It should be recognized that the use of mid-levels as resident providers will normally require the use of circuit-riding physicians to serve as medical supervisors. The need for physician presence at a frontier clinic location will depend upon state supervision requirements.

Each of these different staffing arrangements will have impact upon the ability of a frontier clinic to meet BCRR indicator standards. Some resident providers (particularly physicians) will have difficulty meeting productivity standards for the reasons outlined above in the section discussing utlization in frontier areas. For circuit-riding providers, a substantial portion of work time will be consumed in non-productive travel. Frontier clinics using circuit riding providers will have lower productivity rates if the time spent on travel is not removed from the the calculation. In any event, the travel time of these providers will increase the cost per medical encounter as well as reduce the charges as a percent of reimburseable cost.

C. Specific Recommendations

1. Sites Recommended for Different Standards

It is our recommendation that several special standards be applied to frontier primary care sites. These standards should recognize the emergent factors affecting practice in these areas. The special standards should be applied to clinic sites in frontier areas which are staffed by no more than one or two providers. They should apply equally to systems of such clinic sites which are operated on a circuit-riding or consortium basis.

2. Adjustment of Current Standards for 4 Major Indicators:

We are recommending adjustment of four major indicator standards for frontier clinics:

- Medical Cost per Encounter
- Team Productivity
- Administrative Cost, and
- Charges as a Percent of Reimburseable Cost.

We are making no recommendation regarding the collections indicator, as this does not appear to be a major problem. The four standards requiring adjustment are the ones given greatest weight in a normal site review. They are also the ones which are most affected by the conditions of frontier practice.

a) Medical Cost per Encounter: We recommend that the current figure of $26 per encounter be increase by one-third to $35 per encounter. This will more accurately reflect higher relative fixed costs, circuit-rider travel costs and longer visit duration.

b) Team Productivity: We recommend that the minimum standard for physician productivity be reduced by 25% from 4200 per year to 3200 per year. Standards for mid-level providers should be raised to reflect the higher level of independence of these personnel in frontier locations. We recommend that the minimum productivity standard for mid-levels be set to 75% of that of a frontier physican at 2400 encounters per year. We also recommend that provider travel time (for both mid-levels and physicians) be excluded from calculation of productivity.

c) Administrative Costs: We recommend that the maximum allowable level of administrative costs be raised from 16% to 24%. This will more accurately reflect the higher relative fixed costs of frontier practices.

d) Charges as a Percentage of Reimburseable Costs: We recommend that the current standard of 90% be reduced to 60%. This will adjust for the higher relative fixed costs and the provider travel costs of frontier practices.

3. Development of New Measures/Standards

The current method of measuring productivity uses the first daily encounter with a provider as the basic unit. As discussed earlier, this is not an accurate measure of productivity in frontier areas. We recommend that an alternative productivity measure be developed for use in frontier areas -- one which measures the amount of service provided to a patient on a visit.

Amount of service can be measured in terms of the number of procedures conducted during a patient visit, or in terms of the amount of service time given to a patient. Either of these two approaches can be used in developing an alternative measure.

a) Number of Procedures: Clinic sites currently have as part of their billing database information regarding multiple services provided on a single patient visit. A new reporting mechanism would need to be developed, but it would be possible to prepare this information. Number of procedures may be somewhat misleading as a measure when compared to service time. Some procedures may take 5 minutes of staff time, while others may take in excess of 15. Nevertheless, a count of procedures would be a better reflection of practice activity than would the current counting approach.

b) Service Minute: The Indian Health Service has used a measure of service minute in evaluating the productivity of some of its clinic operations. This measure of time spent with patients is a potential alternative measure for BCHDA sites. While new reporting mechanisms would need to be developed, many clinics could build upon their billing database to collect this information. Bills contain information on the length of patient visit (e.g. brief, intermediate, comprehensive), and this could be converted into a service minute equivalent.

FRONTIER BCBA ANALYSIS

--DRAFT-- 2/7/89

SITE #	CALENDAR YEAR	NON CAPITAL TOTAL BUDGET	GRANT AWARD	MEDICAL USERS	ON SITE MEDICAL ENCOUNTERS	MEDICAL FTE	MEDICAL COST PER ENCOUNTER (1)	BCBA PRODUCTIVITY (2)	ADMIN. COST (3)	CHARGES AS A % OF COST	COLLECTIONS AS A % OF CHARGES
		(USD 0's)	(0200-0000)	(1603)	(9011)	(0013)					
1	1985	$137,587	$56,917	830	2,683	0.70	$27.00	3,833	27%	77%	98%
	1986	$127,406	$52,000	812	2,736	0.70	$27.00	3,914	34%	75%	91%
	1987	$101,853	$45,000	720	2,585	0.70	$21.00	3,693	29%	75%	98%
2	1985	$134,108	$48,659	2,195	4,604	0.50	$21.41	6,376	17%	86%	89%
	1986	$176,462	$52,000	1,306	4,073	0.00	$29.18	6,547	27%	67%	96%
	1987	$150,198	$45,000	1,257	4,018	0.70	$20.04	6,700	23%	93%	88%
3	1985	$180,401	$96,241	1,456	5,323	0.00	$25.00	6,634	25%	87%	101%
	1986	$196,928	$76,525	1,720	5,500	0.00	$25.00	6,975	25%	83%	97%
	1987	$213,362	$92,642	1,854	6,129	0.90	$23.00	6,129	19%	99%	91%
4	1985	$194,193	$0	2,934	9,359	1.50	$20.00	5,263	17%	62%	91%
	1986	$233,690	$117,319	3,814	6,043	1.45	$31.00	6,316	N/A	76%	101%
	1987	$195,920	$163,770	1,852	8,974	2.50	$36.00	3,590	9%	74%	97%
5	1985	$99,904	$46,302	79:	2,120	0.35	$25.11	6,000	15%	86%	70%
	1986	$91,847	$37,670	902	2,581	0.53	$25.74	6,916	21%	71%	100%
	1987	$100,725	$18,309	870	2,681	0.55	$25.43	6,875	18%	72%	96%
6	1985	$323,913	$0	1,330	6,173	1.75	$20.00	3,631	13%	89%	92%
	1986	$348,842	$0	2,485	7,039	1.45	$22.00	4,854	14%	97%	88%
	1987	$324,581	$0	814	4,864	0.00	$20.00	6,485	17%	110%	76%
7	1985	$1,944,163	$1,530,391	13,200	24,699	6.20	$32.00	6,320	17%	91%	85%
	1986	$2,625,367	$2,006,117	12,346	28,726	6.05	$33.00	5,923	15%	91%	82%
	1987	$2,499,942	$1,682,164	14,220	31,586	6.30	$27.00	5,915	16%	76%	81%
8	1985	$2,029,367	$535,367	7,955	30,416	6.35	$20.89	6,790	15%	93%	77%
	1986	$1,250,375	$709,381	5,970	19,975	5.10	$37.26	3,873	10%	76%	116%
	1987	$2,420,611	$1,334,894	9,975	21,355	5.32	$30.45	4,010	17%	97%	93%
9	1985	$169,615	$245,000	1,646	4,259	1.24	$26.75	3,986	20%	64%	81%
	1986	$309,322	$245,000	1,826	5,100	1.60	$26.67	3,131	10%	57%	89%
	1987	$511,535	$305,555	1,797	5,323	1.67	$30.00	3,107	23%	42%	95%
10	1985	$700,030	$402,544	3,529	9,917	2.93	$23.68	3,362	15%	52%	96%
	1986	$907,500	$411,054	4,011	10,525	2.48	$26.84	4,244	16%	44%	79%
	1987	$1,137,082	$403,054	3,055	6,225	3.00	$31.90	2,075	22%	41%	84%
AVERAGE		$653,659	$423,470	3,370	9,137	2.00	$28.97	4,747	19%	77%	91%

DRAFT

Health Services Research

Vol. 23, No. 6

February 1988

Special Issue: A Rural Health Services Research Agenda

Summary

A Research Agenda for Rural Health Services

Alice S. Hersh and Robert T. Van Hook

The organization, financing, and delivery of quality health care services to residents of rural areas remains an important area of concern for policymakers who must deal with the broad spectrum of issues affecting the nation's health. Without a clear understanding of the health care needs of rural residents and the efficacy of programs that seek to meet these needs, these populations will be unlikely to realize equity in health care access, quality, or affordable cost.

In this final article, we provide a synthesis of the recommendations for needed research on rural health care identified by the more than 165 experts who participated in the Rural Health Services Research Agenda Conference sponsored by the National Rural Health Association and the Foundation for Health Services Research. The conference took place December 13–15, 1987, in San Diego, California. This issue of *Health Services Research* includes the eight background papers prepared prior to the conference and a list of conference participants. The recommendations summarized in this article were drawn from the salient issues discussed in the papers and in the proceedings of the conference.

It is our hope that the availability of this synthesis of recommendations from the six conference working groups will stimulate a larger number of qualified researchers and policy analysts to devote significant effort to finding answers to the questions raised. Moreover, it is hoped that the agenda will represent a useful framework for the mapping of future policy initiatives related to rural health care.

Item 2

CROSS-CUTTING THEMES

Although the conference was organized according to six topical areas, hospitals, primary care, alternate delivery systems, the poor and

underserved, maternal and child health, and the elderly, six cross-cutting issues and problems that were of generic importance to each of the principal conference themes emerged during the conference deliberations.

Cross-Cutting Issue No. 1: The need for complementary definitions of rurality. There are numerous definitions of "rural" as well as other equivalent or nearly equivalent terms, such as "nonmetropolitan," "frontier," or "rural-farm." The divergent definitions of these various terms make data from one government agency incompatible with data from another in analyzing rural populations. The development of systems of community definitions of rural areas should be standardized or coordinated, and should also reflect the diversity of rural communities, which range from very isolated, sparsely populated areas to communities adjacent to urban areas.

Cross-Cutting Issue No. 2: The need for additional secondary analysis of existing data bases and the compilation of those existing data into small area units. While major national surveys, like the National Health Interview Survey and the National Medical Care Expenditure Survey, collect data by place of residence, their reports rarely aggregate data by residence or location, and the analyses that simply compare metropolitan and nonmetropolitan groups often mask important differences and trends across nonmetropolitan communities. Special analyses beyond routine report formats are often prohibitively expensive and time-consuming. The variability of health status and medical practice across small areas has been demonstrated in many places; there may be an underlying rural dimension to these variations and the ability to classify data by small geographic areas will help us understand more of this phenomenon.

Cross-Cutting Issue No. 3: Problems related to the recruitment, retention and training of health manpower for rural areas. Despite what is perceived to be an overall surplus of physicians in the United States, rural communities continue to have difficulty attracting and keeping not only physicians, but nurses and allied health professionals as well. Much is known about the factors that influence physicians to choose to practice and remain in rural communities, but far less is known about other categories of manpower who may have great influence on physicians' decisions to initially locate or stay within rural practice situations. System-wide changes in health care regulation and financing, as well as competition from urban and suburban providers, may have much more effect on the current rural health manpower climate than the factors pointed out in earlier research. Much of the medical care deliv-

34-175 0 - 90 - 7

urban and rural areas. Rural practitioners and health care institutions may be at a disadvantage if quality assurance and assessment activities add a net cost that reduces already low financial margins. Specifically, there is a concern that severity of illness measures used in current studies of health care quality are based on resource inputs that are unrealistic for rural hospitals and health care settings.

Fundamental research covering each of these six cross-cutting issues would provide additional information that would improve the applicability of the specific research recommendations that follow. These transcendent issues have been presented first in order to reflect the consensus of the conference that they are fundamentally applicable and a necessary component of any research agenda for rural health.

The more specific research recommendations are grouped according to the structure of the conference. They represent no ordering of priorities; each is of equal importance in a meaningful national research agenda on rural health care. This article both summarizes the deliberations and discussions of the working groups and synthesizes their respective recommendations.

Rural Hospitals

The existence of a large number of small, rural hospitals has been a unique characteristic of the American health care system since the enactment of the Hill-Burton Hospital Survey and Construction Act of 1946 gave many rural counties and small towns the wherewithal to build them. Rural hospitals are now facing a series of challenges that threaten their survival. Cost-containment efforts by public and private insurers, increased competition from urban providers, and declining occupancy rates combined with severe economic recessions threaten the continued viability of many rural hospitals, particularly those with fewer than 50 beds.

The closure of a rural hospital can jeopardize a community's access to affordable medical services and undermine its economic viability. In many cases, the hospital is not only one of the area's largest employers; it is also the community's key to attracting and retaining physicians, other medical providers, and a variety of community businesses and industries.

Several initiatives have been aimed at providing the management of rural hospitals with the training and resources to cope with tighter economic environments; however, there are little organized data com-

ered in rural, underserved communities has been provided by National Health Service Corps professionals or by practitioners who are or have been required to repay medical school loans with service in specified communities. Yet the federally-supported NHSC program has been curtailed and the states have been slow to step in with alternative loan-forgiveness programs.

Cross-Cutting Issue No. 4: The impact of problems related to professional liability on the rural health care system. An important aspect of the rural health care delivery environment has been the sudden and dramatic rise in malpractice premiums charged to practitioners. The greatest percentage increases appear to have been applied to primary care physicians and obstetricians/gynecologists who provide obstetrical services in rural communities. The impact of the growth in professional liability insurance rates has been to force a number of physicians, in both primary care specialties and obstetrics/gynecology, to constrict their scope of practice and to exclude obstetrical services, or to refuse to accept patients with reduced ability to pay or those covered by Medicaid. The dimensions and implications of this problem have not been fully determined. There is great potential for spill-over effects on the financial viability of small and rural hospitals and in the delivery of related health services.

Cross-Cutting Issue No. 5: Problems of transportation in rural areas. A key to access to health care needs for many rural residents, especially the elderly and the poor, lies in their ability to travel to a health care delivery unit. Geographic distances, difficult terrain, inadequate or non-existent public transportation systems, and poor roads can all be barriers to access to health care services. Transportation needs will only be compounded as services are regionalized and the vertical integration of services (from emergency services through primary and secondary care to services provided by referral centers) occurs over a large area.

Cross-Cutting Issue No. 6: The need for a rural perspective in discussions and recommendations regarding health care quality. Issues of quality are of paramount importance as the effects of regulatory and financing reforms combine with fundamental changes in practice content and an increasing reliance on technology to alter the delivery of personal health services. The assessment of quality of care has shifted from process to outcomes measures and quality assurance has moved from a peripheral position dominated by practitioners to an integral part of financing, training, and regulatory activities. The complexity of quality assessment and quality assurance may produce a gap between

paring the various strategies that have been and are being used. At the same time, the preservation of a rural hospital may not be the most efficient or effective use of resources, and its problems may serve to counteract any of the positive economic effects of having a hospital located in a rural community.

Some rural hospitals succeed while others struggle and sometimes fail. The conference participants were very interested in determining both the factors that account for this difference in outcome and the relative dependence of rural hospitals on environmental factors, including competition. The role the hospital plays in the broader economic life of the community also needs to be studied more deeply.

Recommendation 1. Descriptive and analytical studies should be undertaken to determine the internal and external predictors of rural hospital economic viability and the economic effects of rural hospital survival and closure.

The current Medicare and Medicaid payment methodologies function generally to the detriment of rural and small hospitals, both through their reliance on prepayment based on the DRG system and on provider reimbursement formulas that favor specialists and complex procedures. The specific effects of these systems and the prospective effects of any new resource-based valuation system are not known.

Recommendation 2. The fiscal environments of rural hospitals should be examined in depth, especially the effects of prospective payment programs sponsored by the federal government and other changes in payments and reimbursement arrangements.

The inputs to quality of care and its measurement may have important rural dimensions. These may relate to the volume-outcome hypothesis as well as to the additional marginal costs that some quality assurance activities may have on rural health delivery. The regionalization of care may or may not provide opportunities to improve quality, and there is no consensus identifying the proper, minimal mix of services that should be guaranteed in small, remote, or agricultural communities to ensure the highest quality and optimal outcomes for health care under conditions where scarcity prevails.

Recommendation 3. Studies of quality measures and quality assurance should focus on the influences of rural hospital characteristics, especially volume effects and the burden of quality assessment.

POPULATION ESTIMATES -- WY

COUNTY	1988	1986	CITY/TOWN	POP.
Albany	28,600	25,200	Laramie	27,066
Big Horn	11,500	12,300	Greybull	2,157
			Lovell	2,325
Campbell	32,800	36,800	Gillette	17,452
Carbon	15,400	19,300	Rawlins	10,623
Converse	12,200	13,800	Douglas	5,158
			Glenrock	2,332
Crook	5,800	6,000	Sundance	1,184
Fremont	33,900	35,600	Lander	8,154
			Riverton	10,053
			Dubois	1,005
Goshen	12,500	12,700	Torrington	6,145
Hot Springs	5,500	6,000	Thermopolis	4,153
Johnson	6,500	6,500	Buffalo	3,768
Laramie	75,200	75,000	Cheyenne	51,142
Lincoln	14,500	15,500	Afton	1,608
			Cokeville	557
			Kemmerer	4,177
			Diamondville	1,130
Natrona	64,700	70,800	Casper	47,305
			Evansville	2,132
Niobrara	2,500	3,100	Lusk	1,817
Park	24,200	25,000	Cody	7,968
			Powell	5,776
Platte	9,600	9,900	Wheatland	4,777
Sheridan	25,100	26,100	Sheridan	15,112
Sublette	5,200	6,200	Marbleton	706
			Big Piney	778
			Pinedale	1,258
Sweetwater	43,300	46,900	Rock Springs	19,884
			Green River	13,095
Teton	11,600	10,800	Jackson	5,528
Uinta	18,800	21,100	Evanston	11,870
			Lyman	2,491
Washakie	9,200	10,000	Worland	6,861
Weston	7,300	7,900	Newcastle	3,681
			Upton	1,222

Item 3

July 17, 1990

Home Oxygen Plus Equipment in Gillette services the whole north-eastern part of the state, on call 24 hours a day. We have had patients 30 miles north in Spotted Horse, 40 miles south and we go east all the way to the South Dakota border 80+ miles away. We have patients in Moorcroft, Upton, Newcastle, ~~Haven~~, Osage, Sundance, and Alva. We average going over that way once a week or sometimes on the week-end. We have 13 Oxygen patients in the Gillette area, 4 Oxygen patients in the Moorcroft-Pine Haven area, 1 Oxygen patient in Upton, 2 Hospital beds in NewCastle and 1 in Alva over by Hulette. We service the same area with the exception of Gillette for the American Cancer Society. We also sale and service many other home care supplies to this area.

Thank You,

Susan

HOPE Gillette

Dear Hal,

the following is a list of towns we currently have pts in. We service these people once a month and provide them 24 hr emergency service if they need it:

		Miles one-way	Road Condition
Wheatland	Wy.	70	Interstate
Clearwater	Wy.	45	County Rd. - grave
torrington	Wy.	94	County Rd. paved
Lagrange	Wy.	58	County Rd paved
Pine Bluffs	Wy.	45	Interstate
Carpentar	Wy.	34	Co. Rd. Paved
Mitchell	NE.	110	Co. Rd. paved
Scottsbluff	NE	125	Co. Rd. paved
Kimball	NE	65	Interstate
Minnetare	NE	125	Co. Rd grave
Gering	NE	120	Co. Rd paved
Ogallala	NE	178	Interstate
Chappell	NE	130	Interstate
Bushnell	NE.	53	Interstate
Ft. Collins	CO.	54	Interstate
Ault	CO.	50	Co. Rd. paved
Greeley	CO.	60	Co. Rd paved
Loveland	CO.	60	Interstate
Longmont	CO.	78	Interstate
Standley	CO	130	gravel + paved

07/18/90 12:04 6878878878 002

Sterling Co 12m Grant + Dewey

07/18/98 12:04 6378078878 002

We had 2 incidences in Sterling Co. when were at appointments to do our monthly visits and the people weren't home.

We had to go to Laramie one night to plug in a concentrator because the guy was too drunk to do it himself. (No Joke!)

We've gone out several times after people have called and said the concentrators aren't working then we go out and they're working fine.

Note: All these out of town people have K-tank back-ups that Medicare doesn't pay for.

Jake

7-17-90

To whom it may Concern:

I have been asked to substantiate why I feel providers in frontier areas such as the great State of Wyo need additional reimbursement above the current inadequate provision.

I think of the many customers we've serviced over the years in & around the Fort Washakie area. The winter I had to struggle through 40-70 inches of snow and carrying a liquid O2 reservoir about 200 lbs because of vehicles stranded in the road to deliver to Alberta Driver. I seriously considered a toboggan & snow shoes for deliveries that winter. More recently Vernon Armour on 4 lpm via O_2 Concentrator but going thru E-tanks like there was no tomorrow & its approx 100 miles round trip & he always needed E's in the middle of the week- my normal schedule was each Monday- and we were getting reimbursed the equivalent of one (1) E contents & the rental. You feel like somebody has kicked you in the belly or pulled the drain plug on your wallet but you have to do it.

Frank Hindman an old rancher

near Crowheart called me out one time to check out the concentrator he had over for several years. I tried to talk him thru it over the phone but no I had to come, the machine was broke down. I loaded up a machine bundled the kids in the truck, their mother was working, (-30° so I put the kids in sleeping bags & by midnight I was on the scene to push in the re-set button & get the machine going again. Now how much do you suppose we were reimbursed for that 110 mile midnight ride. — I think you've guessed it!!!" O"

How about the trips to Dubois to provide liquid O_2 to Frank Welty Jr (160 miles round trip) because both Frank & his wife thought the tank was Empty - it was still half full they just couldn't read. Again there is no recourse for the provider you just smile, pat them on the shoulder & be on your way.

Consider Richard Glasgow in Pavillion (50 miles round trip) who can not get out of his bed & try as we might we cannot talk his wife thru changing out the

defective humidifier bottle (There were two new ones available but she not mentally able to be instructed – Again miles of miles of fuel consumption & wear & tear on the company truck for what.

Now I'll bet you didn't know that there is one fellow in Jeffrey City, Wy who requires supplemental O2. You scratch your head & wonder how you can make a dime going 100-120 miles round trip to provide service to (1) one customer, but whatever the cost it must be done.

You see gentlemen if you are very, very fortunate you may be able to put together a compliment of three or four customers in a remote area & perhaps make a buck but a few call-outs, nuisance calls, can wipe out your profit and what of the single customer base in some remote area (you must provide the service) but to do it & survive is a bigger question.

Sincerely,

Ron Fay, manager
Fremont Co. Wy

4 -

P.S. I would be quite remiss in doing this if I did not recall Mr Richard Blust who called me all times of the day & night from Dubois to bring a different machine — Have you ever had to pack an Econo2, weighing 115#s, up a narrow steep stair well — Richard roomed above the Rowlson in Dubois, 78 miles to Dubois a long ways to go to change out a Concentric or deliver an E'cyl for little or no reimbursement. It's sad to say but I didn't shed a tear when I no longer needed to take care of Richard - I tried many times to give him away — with no success.

H.O.P.E. Worland and Big Horn Basin

We service about 50 to 60 patients we drive about 950 to 1200 miles per week to service these patients.

at the present time we service a patient liquid O2, at her doctors orders, to a ranch in Clark Wy. Her Oxygen saturation will drop extremely low as just a few minutes with this condition, we have [redacted] of the trips when extreme with weather has been forecast. We had to use a four wheel drive vehicle to set this patient up with Oxygen.

about two weeks ago, I delivered Oxygen to Greybull, about 42 miles from Worland, I had just returned to worland and had to go back to Greybull to repair a pulmonaide During the summer months we had a patient who lived 44 miles south of Ten Sleep (about 154 miles from our Cody office) I was called this one night about 11 PM as the alarm was sounding periodically. this patient was very dependant on Oxygen. I delivered a different concentrator and returned nearly to Ten Sleep when I was called back as the alarm was sounding on the concentrator I just delivered. After monitoring

SENT BY:A 7-19-90 10:07AM 3873472133+ 307 577 1521;# 3

the concentrator for about an hour, we noticed the lights become much brighter. After checking with the power company we found out there had been a power shortage. This call took 360 miles (2 trips) of a windy gravel road and 2 or 10 hours time with no revenue to the company whatsoever.

Since 1982 I have driven 432,000 miles in northwestern Wyoming to give our patients the service and peace of mind they deserve. I am sure at least 30% of the time and miles are not reimbursed.

I set up a concentrator for a patient in Hamilton Dome (about 100 miles one way). I was called back the next day to pick up the oxygen equipment as the patient had expired.

We cover the towns of Worland, Thermopolis, Cody, Meeteetse, Tensleep, Kirtville, Grass Creek, Manderson, Otto, Burlington, Powell, Clark, Byron, Cowley, Frannie, Hamilton Dome on a few more here and there.

As manager of the Rock Springs branch of Home Oxygen Plus Equipment, I also deliver oxygen of all types and sizes to a very diverse people. Men and Women with all types of diseases and ages. Principally, I deliver to Medicare Patients, but the amount of money paid by Medicare is very scarce. When Medicare pays less it means private insurance must pay more. As a business man I know when your own costs for materials goes up, you must charge more for your services. This means the private insurance carriers must increase their premiums to their customers. This customer is our patient trying to scrape out a living on a very fixed, low paying social security income. I see these people "crying mad" at Home Oxygen Plus Equipment simply for the fact Medicare has paid less on their bill making us bill them for the difference. This hurts these people who in their "Golden Years" are forced to do with less and less because some bureaucracy deems it necessary to cut the old folks benefits. In the land of plenty the majority are discriminated against financially. I deliver oxygen in a 100 mile radius around Rock Springs. My

JUL-19-90 THU 9:15 . P.05

vehicle is a 1982 3/4 ton pickup that averages 4,000 miles per month. We have replaced the motor 4 time since it was new. As you can see vehicle costs are astronomical. Some of the territory I cover is from 7,000 feet at Evanston to about 8,500 feet elevation at Bondurant. Many days in the winter we get snowed "out" or "in" forcing us to live on the economy (motels, cafes etc.). Fuel costs for our vehicle have gone up, but Medicare benefits paid out have gone down.

No business can ever survive by breaking even, but Medicare does not realize this because it is a bureaucracy thriving on mismanagement. A democratic society has free enterprise thriving because of profits. Profits pay bonuses a bureaucracy does not. Profits make business efficient, a bureaucracy does not. Private enterprise is stifled by government red tape. The bureaucrat justifies his existence by increased government laws and regulations. The number of Medicare recipients

have increased dramatically, but when they need help medically, Medicare is not there. This is the very reason Medicare was started by helping defray the cost of rising medical costs. "We the people are taking it in the shorts financially because Medicare has shortened their long range goals. We can pay out millions in foreign aid to other countries including Russia, but we cannot afford (because of Gramm-Rudman) to pay the cost for the best medical care on this earth. In the United States of America can you imagine a medical trained technician giving aide to a baby because of a recycled, contaminated hypodermic needle. Romania did. We have the best nation in the world and we must keep it that way in all fields including medicine. Medicare must pay their share have to help the aged pay their share. That's what the U.S.A. is all about. A nation freely giving of itself to help all peoples.

In Sweetwater County, many, many wage earners are making upwards of $21.00/hr to $25.00/hr. For Home Oxygen Plus Equipment to hire and keep

JUL-19-90 THU 9:11 P.02

qualified, trained personnel, we are forced to compete with these hirer than average wages. Realistically, we cann do that when Medicare is continually decreasing the amounts of monies payed t venders as Home Oxygen Plus Equipment is.

The paperwork demanded by Medicare has become excessiv ~~Forcing~~ Forcing Home Oxygen Plus Equipment to hire a person at each branch to do nothing but chase down paperwork. Doctors are overloaded on paperwork and will unintentionly put off filling out the paperwork for oxygen because it is not required of them. Yet, Medicare will not pay a dim for oxygen until they have that paperwork. This leaves Home Oxygen Plus Equipm in the middle between a docto who doesn't want to fill out th papers and Medicare who wo pay until he does. We go by for months without being payed There goes what litt profit we could ever hope to make. The bankers demand their payments on time, but how can we when Medicare is

JUL-19-90 THU 9:09 P.01

7-17-90

To whom it may concern:

I do in home respitory care for the elderly. I make a house call on each of our patients once a month, clean their equipment and do a clinical assesment that is sent to their physician. We currently have 3 patients in Star Valley Wyoming. It is a 5 hour trip one way to get there. In the winter you risk your life getting over the small pass to get into star valley. Last winter we went to Star Valley in a 4 wheel drive pick up - slid off the highway going 15 miles per hour in 4 wh drive with chains on and landed in a burrow pit. We called a wrecker to pull us out - they came and took one look and wouldn't even hook on. We then called a construction Company who came out with a cat, put chain on their outfit, then lifted us out of the

burrow pit.

On one trip to Fort Bridge we hit ice spun, and slid off into a ditch with a 6 foot drift, we were at least 10 miles from the nearest town, after trying to dig out with a window scraper we ended up walking 5 mile in below zero weather to get to our patients house

We also go to manilla Utah, this spring d left rock springs on a warm sunny day. By the time d reached 10 miles out of green River, d was in a snow storm so thick and heavy that you could not see the reflectors on the sides of the roads - let alone the road it's self.

Another trip that stands out in my mind is a trip to pinedale - pinedale is a 2 hour drive from the office that we make at least once a month. This was Early spring - on a beautiful day. D had 2 patients to see that day & almost didnt make it at all -

the wind kept blowing me off the road. This was in a very heavily loaded mid size car. The wind literally kept blowing me off the road. I spotted 4 different wind funnells touching down within one mile of me and it also broke my windshield throwing gravel at the car. What should have been a very pleasent 6 hour day turned into a 9 hour nightmare.

One day last winter I was in Rawlins seeing patients and had to travel from Rawlins to Hanna to see 1 patient. We left for Hanna at about 1 pm and arrived back in Rawlins at about 10:00 pm. We got stuck in a blizzard (we later found out they closed the gates right behind us) and had the 4 wheel drive truck on the freeway and broke the drivers door while trying to push the truck to get it unstuck then

JUL-19-90 THU 9:19 AM 96-13-NHT

had to hold the door closed manually and drive thru the blizzard at the same.

One of our patients in Big Piney didn't get seen 3 months in a row this winter because she was snowed in on her ranch.

4. On the Big Piney / Jabarge area we have 5 patients that live on ranches at least 20 minutes drive from town, all in different areas.

Virgina one time had to hitch a ride with a truck driver after being stuck on the freeway between Rock Springs & Rawlins.

JUL-19-90 THU 9:18 P.07

Item 4

Cody Council on Aging

Phone: (307) 587-8221

Rose Miller, Director

Rolling Meals
Bus Service
Congregate Meals
Senior Companion
Supportive Services

July 20, 1990

Senator Alan Simpson
SD 261, Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senator Simpson:

As Director of the Cody Seniors since 1972, I welcome the opportunity to write my thoughts about living, working and providing services in Wyoming. It is wonderful to live and work here but it has its advantages and disadvantages, which are ahead of the other I haven't figured out yet.

In the Center we employ Green Thumb and SCSEP workers to fill in the spaces our budget won't cover. These jobs also supplement income for seniors with very little income, making their life feel more productive. The income has become a problem because those making a very low income are those who are too old to provide help. This is not always the case, as you know, Frances Purvis, at 90, still can provide, but for the most part it is the case. This includes the Senior Companion program as well. Most seniors would rather work to provide than the other way around.

Another area of concern to me is the cut in transportation funds. You are aware of the necessity of the senior bus. At this time we are transporting not only seniors but two handicapped persons who are trying to hold down jobs at local businesses. We also transport one non-senior to therapy. It is a sad thing to see these young people in need so bad and how hard they are trying to become self supporting. We have contracted with the taxi to pick up the slack and hope that serves two purposes; First, to try to keep the taxi afloat, and second to help relieve the push at peak hours or after we have gone home. This year we cut $6,500.00 from the budget and are looking for bigger cuts next year. Our riders do donate to the bus, some donate generously, some not so much and in fact there are a few who don't give anything, but I am trying to cure that. We use these donations for cash match for program income.

As I get closer to being a senior citizen myself these problems become very apparent to me. After much detailed thought I wonder if a sliding scale to qualify more of the persons for help and not so much for those who get Title 19 at present. This has been a submitted item in the re-entactment of the Older Americans Act. Those on Title 19 seem to be far better off than those in the middle who worked hard to get their wages and have poor health and can't make ends meet.

Non-Profit Organization

613 16th St.
Cody, Wyoming 82414

Cody Council on Aging
Phone: (307) 587-8221

Rose Miller, Director

Rolling Meals
Bus Service
Congregate Meals
Senior Companion
Supportive Services

June 20, 1990
Senator Simpson
Page 2

Thanks for giving us your time, It's a big dilema for everyone and I know I don't have the answers, but I think more heads are better than one and maybe with a lot of thought we can solve some of the problems.

I am submitting some cases prepared by the outreach worker from the center who deals with situations all the time. Hopefully she can help. Our main purpose in this center is to keep persons independent and out of the Long Term Care Center as long as possible with the quality of life they deserve.

We have come a long way since 1972.

Best wishes,

Rose Miller

Rose Miller

Non-Profit Organization

613 16th St.
Cody, Wyoming 82414

June 20, 1990
attachment to letter to
Senator Simpson

CASE NUMBER 1:

We agree with you, those below the poverty level of $513.00 a month have few problems with all medical bills including some prescriptions and what ever else they are entitled to under the program.

But - what about the person (mostly women) that is a few dollars over. Example: She makes $515.00 a month. Only two dollars over and she does not qualify for help. Because she makes two dollars over she has to pay all her medical, prescriptions and all other expenses otherwise covered by D-Pass.

Seems like this could be handled on a sliding scale as an encouragement to stay independent rather than to appear to be more profitable to drop below the poverty line.

CASE NUMBER 2:

A case we worked on, the lady was a senior with Social Security of $285.00 a mont NET, and an unreliable basement rental. She makes a house payment and had to work to make ends meet. She broke her wrist and was unable to work for some time.

Because they count the GROSS income on their assessment she was $16.00 over D-Pass being able to help her. Had they not counted the GROSS FIGURE, which was not a spendable amount, and indeed used the spendable amount, she would have qualified. Her's was a temporary need but a vital one at the time. Again it would seem more profitable to encourage people to take care of themselves, at least when they are willing, than to make it more profitable to sink to the poverty line and let someone else worry about their welfare.

CASE NUMBER 3:

Donna Florida - Cody. Donna is age 45, helpless now to the point she can not even go to the bathroom by herself or get in and out of bed, in fact, can not even turn herself in bed.

Her mother, who is on two crutches, often has to go over in the night and turn her and helps as much as she is able in her condition and with a husband on oxygen all the time...

Donna hires a limited amount of help that she can afford. She filed for permanent disability but has to wait two years to get on Medicaid, which won't be until November of this year.

June 20, 1990
attachment to letter to
Senator Simpson
Page 2 - Case No. 3

She is desperately trying to maintain herself and not go to the nursing home, where it would be considerably more costly. But with a little financial help she could maintain her independence a lot cheaper than the cost of the nursing home.

According to the Billings Gazette, they figure 60 percent of the people going into the nursing home are on Title 19 or D-Pass. Many more are on it within a short time.

It would appear that if people could be encouraged to stay at home with some help, it would be a lot cheaper than State and Federal having to cover them in a nursing home. Donna is a case in point.

If non-seniors could be assessed on their need and condition on an individual basis rather than under a blanket cover of qualifications for Medicare or Medicaid many of them would do as Donna is trying to do, stay independent on her own as long as possible, rather than be in a nursing home with State and Federal paying the bill.

Item 5

Testimony of the Wyoming Medical Society
For inclusion in the record of the
Special Committee on Aging Field Hearing
Chaired by Senator Alan K. Simpson
July 23, 1990
Casper, Wyoming

Senator Simpson and distinguished Committee members:

On behalf of the Wyoming Medical Society and its members, I thank you and the Special Committee on Aging for meeting in Wyoming recently to hear testimony on rural health care. We are most appreciative of your continuing recognition and support of the special circumstances of health care delivery in Wyoming's frontier setting. Your efforts to bring a better understanding of the needs of frontier areas to member of this Committee, and to your colleagues in the Senate is appreciated.

Hearing testimony highlighted a number of different viewpoints within the health care field. From public health concerns to the perspectives of hospitals, physicians, senior citizens and others, persuasive arguments were given to why the needs of frontier areas should be considered as unique from any other region or category.

As you are well aware, one of the most pressing concerns of physicians in rural and frontier states is the issue of geographic disparity provisions of the Medicare reimbursement system. Medicare beneficiaries and health care providers are, under today's system, reimbursed widely different amounts for the same medical procedures based on whether the service is provided in an "urban" or "rural" location. Reimbursement rates in Wyoming are significantly lower than payments made to providers in urban settings. In one recent analysis, Wyoming was found to have the third lowest reimbursement rate in the nation.

The impacts of inadequate reimbursement are many. First, patients must pay more for the services they receive in order to make up the difference created by low Medicare reimbursements. Wyoming physicians, more and more often, can simply not afford to accept additional Medicare patients. Many physicians are being forced by economic considerations to relocate to other states and urban areas where reimbursement levels are higher. Finally, and perhaps most significantly when talking about adequate access to health care in frontier areas, it becomes increasingly difficult to recruit new physician replacements to practice in Wyoming. Geographic reimbursement inequities are both a disincentive to practice in rural and frontier areas and a disincentive to continue to accept Medicare patients.

This issue is symbolic of numerous policy decisions made at the federal level which do not take into account the impact of such policies on the delivery of health care in frontier areas like Wyoming. While there appears to be growing recognition at the federal level that rural health care is in a threatened status, there does not seem to be corresponding recognition that legislation being considered today will have a significant negative impact on that same fragile system.

For example, provisions of the RBRVS will help alleviate some geographic disparity problems by making more realistic adjustments. Provisions included in OBRA '89, however, will destroy any gains provided under the RBRVS by imposing balance billing limits of 125% of local prevailing fees. Cutting compensation to physicians under the 125% rule will significantly lower revenues for medical services that are scheduled for increases in 1992 under the RBRVS. In addition, the burden of anticipated RBRVS decreases, promised to occur under a gradual, 5-year phase-in, will now be immediately forced on physicians.

Physicians in nearly every state will be affected by the 125% rule. Wyoming, and other states where fees for services are now below the predicted national RBRVS prevailing, will see a particularly harsh impact. The AMA estimates that nearly 17% of Wyoming medical practices will lose over $10,000. To recoup this reduction under the RBRVS provisions may take, in many cases, as long as six years.

The AMA has proposed a one-year delay in implementing the balance billing limits to coincide with the phase-in of the RBRVS. Balance billing limits, if put into effect, will short-circuit the protections offered by the 5-year phase-in of the RBRVS and will significantly hurt Wyoming physicians. We would urge this committee to support a one-year delay.

Implementation of regulations for the Clinical Laboratory Improvements Act of 1988 (CLIA '88) is another example. The intent of the legislation is good, but the resulting impacts on physician operated labs in small Wyoming communities may be disastrous. The end result will be further diminished medical services in the areas that are in most need of simple lab capabilities.

The Geographic Practice Cost Index under the Medicare Physician Payment Reform proposal contains yet another example. By implying that the cost of practice in urban areas is greater than in rural, higher reimbursements to urban physicians will continue. As you well understand, many costs of doing business in a rural area, including basic equipment and staff, are the same or higher in rural areas.

Maintaining appropriate funding levels for beneficial federal programs must also be addressed. The National Health Service Corps has the potential to provide assistance to many areas of the nation, but without adequate funding frontier areas will see little benefit.

Maintaining quality health care in a frontier area is a difficult challenge. This challenge should not be made more difficult by federal policies which do not take into full consideration the possible impacts on rural health care delivery systems.

We appreciate this opportunity to share our views on these topics, and trust that the members of the committee will find the information from this hearing helpful. We look forward to a continued dialogue on the issues which are so critical to providing health care to senior citizens in all areas of the nation, and particularly in frontier areas.

Sincerely,

Richard W. Johnson, Jr.
Executive Director
Wyoming Medical Society

Item 6

7/23/90

The Hon. Senator Simpson,

On behalf of the Senior Citizen Centers representing the State of Wyoming, we urgently implore your attention to the severity of problems facing senior programs throughout our "frontier" communities.

1.) The issue of the federal funding formulas which currently focus on minorities; proven not valid in terms of our lack of numbers!

2.) The issue of the poverty levels which exclude those persons on marginal or fixed incomes for many services.

3) The issue of transportation; critical to the needs of older people, handicapped and general public. We must establish sufficient funding to utilize the Urban Mass Transit program. With the exception of Casper and Cheyenne, the state is literally without adequate public transportation.

4.) The issue of preventative health care, currently provided by many of our local senior centers. We must be assured of adequate funding for these services; including in-home services.

5) The issue of continuing our nutrition programs. We must establish the same credibility for the fixed income person, as well as, the low-income, minority and handicapped. The current federal regulations contribute to the waste and higher cost in relation to food preparation and distribution.

Page 2

In conclusion, I fail to see the common sense in allowing the credibility of these senior programs threatened by closure when the census indicates a dramatic rise of the older population in our country. To me, that means we will be re-establishing these programs; (more costly), to accommodate the services needed in the future. Also, I wonder why more attention is not paid to the cost savings realized by the states as a direct result of senior center programming. I refer directly to the issue of medicaid, i.e. nursing home placement. Obviously, that was the objective years ago for senior centers, and it remains constant. The objective: to provide services which enable older people to remain in their homes for as long as possible..... We must stabilize funding.

I wonder if I will live long enough to ever understand and accept the workings of the federal government as it relates to domestic programming.

Thus far, I see a tragic lack of horse-sense; stable thinking; when it comes to addressing the needs of our society at large. I am reminded of Hubert Humphrey's statement: "The success of a community; our societies can be measured by the care of the children, elderly, and handicapped"

continued

If one uses the analogy of domestic programs symbolized by various specialized ships; protecting the waters and marine life contained within; we are sinking ——— by the rough fabricated waves of legislation by our Federal government.

This is a very sad commentary as it relates to the general safety and security that can be made possible through quality health, nutrition, transportation and general life services that people deserve.

Sincerely,
Evelyn Hoover
Project Director
Glenrock Senior Citizens, Inc

Read by, and nod of approval given:

Mildred A. Barber
Mildred Barber-Board Member G.C.S.I.

Loretta Whisenant
Loretta Whisenant - Board Member G.C.S.I.
Silver Haired Legislator

Item 7

LEON CLYDE PRUETT
SUPERINTENDENT

ANUP S. SIDHU, M.D.
CLINICAL DIRECTOR

STATE OF WYOMING
Wyoming State Hospital

BOX 177 EVANSTON, WYOMING 82931-0177 (307) 789-3464

August 2, 1990

Leslie Tucker
Office of Senator Alan K. Simpson
261 Dirksen
Senate Office Building
Washington, D.C. 20510

Dear Leslie,

Enclosed is the written testimony regarding those individuals in our mental health system who have been affected by the OBRA PASARR reviews. As you know, due to the tremedous distances between communities and the lack of financial as well as human resources, the state of Wyoming has often had to become creative in meeting the needs of their citizens. The nursing homes in Wyoming have cooperated with the Wyoming State Hospital in arranging placements for individuals who have reached a degree of stability on their medications where they are no longer a danger to themselves or to others. In the nursing home setting, these individuals have been provided with structure, which helps them to organize their thoughts, and supervision. But more than that, the nursing homes have been able to provide these individuals with a feeling of safety and of living with people who care about them in a setting that they can call home.

The nursing homes have provided these individuals with activities and made every effort to assist them in having a meaningful life. The individuals have responded favorably to this situation. Some individuals have resided in the nursing facility for several years and for them, it is home. Others are able to maintain for a period of six months to a year. Then, despite their being on medications, their mental illness exacerbates which often results in a deterioration in their behavior sufficient to warrent a return to the Wyoming State Hospital. In the past, we have been able to treat these people until they are once again stable and suitable for release back to the nursing home.

While residing in the nursing facility, these individuals have an opportunity to associate with "normal" individuals and often this helps them organize their thinking and maintain more appropriate behaviors. The four individuals who are currently residing in nursing facilities have been able to integrate into that population and are accepted by both the staff and other residents. These individuals have been able to make friends. They are able to feel as though they are part of the group. These individuals have complied with their individual treatment programs and worked hard to be able to maintain behaviors that are appropriate so that they can continue to reside in the nursing facility. Now due to the results of the OBRA screening, these individuals will be returning the more

restrictive environment of the state hospital. This return is not necessary due to a deterioration in their behavior, but rather because there is no other alternative placement setting.

The nursing home may not be the most ideal setting for these individuals, however, many of their care techniques are as beneficial for the frail mentally ill as they are for the elderly. It is important to realize that Wyoming State Hospital has not engaged in massive deinstitutionalization to the nursing homes. We have only placed a few select individuals that have had the potential to benefit from that type of placement setting.

Due to the OBRA screenings, these individuals are no longer able to leave the state hospital and enter into more of a community life situation. These individuals are in fact going to have to return to the state hospital or continue reside in the state hospital as there is no alternative placement available at this time. Due to the small population base in Wyoming, it is often difficult to obtain the necessary financial and human resources to create residential community programs. The type of program necessary for these individuals would be so similiar to that of the nursing facility programs that it could be considered as a duplicate program.

There is not enough of a population base to warrent the development of duplicate type programs in these small communities. The distances between communities prohibits opportunities for the communities to share programs. Few of our towns have taxi services and many towns lack any form of public transportation either into or out of town. A possible outcome of developing a program specifically for these individuals would be that it would be located in one area rather than throughout the state. Considering the resident population, it could very easily develop into more of an institutional setting than the community type program seen in the nursing facility.

We appreciate your interest in this matter. If we can be of any further assistance, please do not hestitate to contact us.

Sincerely,

Mary Kramer
Nursing Facility Placement Coordinator

Leon Clyde Pruett
Superintendent

Written Testimony Wyoming State Hospital August 2, 1990

Harry

Harry is a sixty-four male who experienced his first psychiatric hospitalization at Wyoming State Hospital (WSH) in 1953. He has also been hospitalized in California and Nevada. When he was not hospitalized, Harry would live in board and care homes utilizing funding from S.S.I. Harry hears voices, sees pictures that are not there and has a belief that electricity is running everyone. He has had eleven known psychiatric hospitalizations.

His most current admission occurred as a return from a nursing facility. His adjustment had been adequate at that nursing facility for almost a year. He reports he started having suicidal thoughts and hallucinations. His behavior started to deteriorate and he required readmission to WSH.

While at WSH, Harry has experienced a deterioration in his physical well being and a stabilitzation in his mood. He is able to utilize grounds passes on a daily basis with no unauthorized absences. He will attend activities when encouraged, however, he does not volunteer to participate. At this time, Harry has asked staff to arrange for nursing home placement.

Staff have reviewd this request and have found it to be appropriate. Harry is seen as a cooperative patient. He has repeatedly demonstrated that he will not take his medications when unsupervised. However, when administered by licensed staff, Harry is compliant with taking his medications. He is able to attend to his own daily living needs, such as bathing, without reminding.

We have discussed the possibility of a board and care facility for Harry. However, there are very few of these available in the state. The most important issue is that they are unable to provide the necessary structure for Harry. For an individual with numerous disorganized thoughts, structure and routine can be assist them in organizing their own thinking.

What Harry needs to function in the community is a program where there is some organized structure, supervision and administration of medications and an individual program that will encourage him to interact with his environment in a meaningful and appropriate fashion. Left on his own, Harry will focus on his own thinking and experience a deterioration.

In our efforts to secure a placement for Harry, we contacted a nursing facility that has been successful in providing programing for other patients from our hospital. This facility offers an active therapy program. They are also able to provide the necessary supervision for Harry's medications. We discussed this facility with Harry and he agreed that he would be willing to live there. The nursing facility also felt that they would be able to meet Harry's care needs.

The nursing facility initiated the OBRA screening. The OBRA screening resulted in the state mental health office stating that he is not appropriate for nursing facility placement and continues to require active treatment. There is no placement setting in Wyoming where he can receive "active treatment" except the state hospital. There is one group home for the mentally ill that often has a population of two to three residents. They are not able to provide the level of structure and supervision necessary to assist Harry in maintaining at his current functional level.

Most of the planning for services for the mentally ill are focused towards the young chronic patient. Harry is older than most of the individuals considered for placement. He also has no desire nor is there any reason to expect to him pursue vocational goals at this stage in his life. He would like to live where he can be comfortable. Living in a nursing facility would provide him an opportunity to live with individuals close to his age, to experience more of a community life and to have an opportunity to integrate with more of a normal population.

Written Testimony Wyoming State Hospital August 2, 1990

William

William is a fifty-eight year old male who was first admitted to WSH in 1950 at the age of eightteen. He remained in the hospital until 1988 when he was released to a nursing facility. Initial adjustment appeared adequate, however, by the spring of 1989 he started demonstrating threatening behaviors. Reportedly he was making unprovoked threats to staff and other residents in the home. Two other residents who had previously been patients at WSH had engaged in inappropriate behaviors necessitating their return. Bill apparently felt insecure at being left behind and so he indicated that he wanted to return also, that he was tired of living with old people. Due to the belief that he would follow through with his threats if forced to stay at the nursing home, he was returned to this hospital.

William has participated in the Social Rehabilitation Treatment Program throughout this hospitalization. He has continued to have a problem with verbal outbursts. He tends to get loud when he is excited. He can be calmed down by having staff talk with him. Short time-out periods have also proven effective in management of his behavior. While Bill continues to have the ability to become assaultive, it is felt that with management techniques this behavior can be controlled.

His physical health has deteriorated over the past years as he suffers from grand mal epilepsy and neurodermatiis of his lower extremities. As a young man, he underwent a transorbital lobotomy. At this time he requires assistance for bathing and proper eating habits. He has periodic incontinence and also tends to eat his food too fast resulting in choking.

We were able to locate a nursing facility that was willing to work with William. The OBRA screening found him too much of a behavioral mangement problem for placement. Recently we had William seen by Dr. John Ratey, M.D., a psychiatric consultant from Boston. His impressions were that William could tolerate community life if he were provided with activity throughout most of the day. While he did see William as eventually able to live in a community group home, he thought that he would need a trasitional period prior to that level of independence.

Written Testimony Wyoming State Hospital August 2, 1990

Ralph

Ralph is a thirty-three year old male who has resided at a nursing facility for approximately two years. He had been hospitalized at Wyoming State Hospital for two years prior to his placement at the nursing facility. His hositalization at Wyoming State Hospital was precipitated by a violent attack on his mother whom he threw down a flight of stairs. During his hospitalization, he displayed minimal motivation and had been unwilling to participate in any activities to help himself. While in the nursing facility, Ralph has been seen by various counselors from the Carbon County Counseling Center. Attempts were made to place Ralph in the ARC program, a developmental disability program, as well as in the Lodge, a program for individuals with mental illness. He was not accepted in either of these programs. Formal counseling with the Carbon County Counseling Center was terminated due to Ralph's lack of motivation.

The staff at the nursing facility worked very slowly with Ralph to gain his trust. He responded well to their activity therapy program and currently is involved with leather craft. The most significant change, however, it that at the present time Ralph enjoys going places with the staff. He will go with the activity therapist to shop for other residents. On one occasion he was able to go to Casper to shop in the mall. At this time, Ralph enjoys going along with staff when they do errands in town.

While Ralph has made some significant gains, it is important to note that he does continue to have days when he appears anxious and he has utilized at least one p.r.n. medication per month to control his behavior. He has stated that he would like to return to his home to live, however, his parents refuse to have him live with them. They and the staff at the nursing facility believe that on his own in his old home town that he would once again return to abusing alcohol and drugs and become a severe management problem. There was one occasion at the nursing facility when Ralph left the facility on his own and went to the Senior Citizen's Center where he stole money from their coffee kitty. He was confronted and provided with closer supervision as a result. There is concern that left to his own devices he would engage in asocial behavior.

As part of the OBRA process, Ralph was recently evaluated as to his appropriateness to reside in the nursing facility. The mental health professional evaluating his case reported that Ralph is basically quiet and passive with occasional agitation. Ralph was seen as withdrawn and had a flat affect. Observation of Ralph revealed that he continues to hallucinate regularly in that he speaks to people who are not present. In summary, the mental health professional stated that Ralph's psychiatric disorder was well managed by medication and that he was functioning at his optimal level within the least restrictive environment. His recommendation was Ralph remain in the nursing facility.

The state mental health office has indicated that due to the nature of the OBRA legislation, they would be recommending that Ralph did not require active treatment and should be placed in an alternative setting.

Efforts have been made to select an alternative placement setting for Ralph. He was evaluated by staff from the group home for mentally ill individuals in Green River. They reported that he lacked the necessary skills and functional ability to be considered for their program. They also questioned their ability to prevent his returning to living on his own with a subsequent fear that he would then become noncompliant with his medications and deteriorate to the point of requiring active treatment.

While the nursing facility may not be the most ideal placement situation for Ralph, it has provided him with an opportunity to live in a less restrictive setting than the state hospital. His lack of motivation to become involved in any program that would require his active participation creates a major hurdle in placement efforts. The programs provided for him at the nursing facility offer him something to do with each day without pushing him into a stressful situation.

At this time, there is no facility in Wyoming that would be able to provide Ralph with the support necessary for him to maintain at his current functioning level. The nuturing type of support provided by the nursing facility staff has been instrumental in Ralph's progress. In a state with limited population, human resources are not always available unless agencies are willing to become flexible. In a state with a larger population base, there would be enough persons with Ralph's particular care needs to justify to creation of a separate treatment program. However, where his needs are for nuturing and support, this has best been provided by the nursing facility staff trained in provided similar care to the elderly.

Written Testimony Wyoming State Hospital August 2, 1990

Joanne

Joanne is a fifty-two year old female who entered the nursing facility in 1988 following treatment at WSH. Prior to her hospitalization, Joanne had been residing in a hotel where she received some supervision. However, she stopped taking her psychotropic medications and then started to decompensate. She reported seeing bright colors coming out of the walls and hearing voices. She stabbed herself in the abdomen to get the bad things that were inside of her out of her system.

While at WSH, Joanne continued to express a fearfulness about living alone. Attempts were made to have her transition out of the hospital by residing on a hall with minimal supervision. She deteriorated and required a returned to a more structured setting. While hospitalized, Joanne was cooperative with taking her medications and participated in all of her assigned therapies. When her behavior became sufficiently stable to consider release, she became upset at any plans that entailed a reduction in the amount of supervision. For this reason, placement in the nursing facility appeared appropriate.

During her residence in the nursing facility, Joanne has slowly gained in her self confidence. She has received considerable support and encouragement from the staff and been allowed an opportunity to progress, At this time she is active in the resident government, has started to use her typing skills on a limited basis and completed a trip to Casper to shop in the mall. She was accompanied by staff and other residents on this trip.

The state mental health office has indicated that due to the nature of the OBRA legislation, they would be recommending that Joanne did not require active treatment and should be placed in an alternative setting.

Efforts have been made to select an alternative placement setting for Joanne. She was evaluated by staff from the group home for mentally ill individuals in Green River. They reported that was she cooperative, however, she lacked the confidence to utilize public transportation to their facility. That staff felt that Joanne would find the level of independence too stressful and would decompensate to the point of requiring active treatment.

While the nursing facility may not be the most ideal placement situation for Joanne, it has provided her with an opportunity to live in a less restrictive setting than the state hospital. Her lack of independent living skills creates a major hurdle in placement efforts. The programs provided for her at the nursing facility offer her meaningful activity each day without pushing her into a stressful situation.

At this time, there is no facility in Wyoming that would be able to provide Joanne with the support necessary for her to maintain at her current functioning level. The nuturing type of support provided by the nursing facility staff has been instrumental in Joanne's progress. In a state with limited population, human resources are not always available unless agencies are willing to become flexible. In a state with a larger population base, there would be enough persons with Joanne's particular care needs to justify to creation of a separate treatment program. However, where his needs are for nuturing and support, this has best been provided by the nursing facility staff trained in provided similar care to the elderly.

Written Testimony Wyoming State Hospital August 2, 1990

Duvall

Duvall is a fifty-eight year old who had been in Colorado State Hospital as well as Fort Logan Mental Health Center prior to his placement in a Colorado nursing facility. He continued to exhibit some problematic behaviors that staff felt were due to his being in too large of a facility. Arrangements were made eight years ago for his placement in a small nursing facility in Wyoming.

His adjustment to this facility has been good. He has certain "chores" that he does each day, such as checking the current outside temperature and looking to make certain that the pop is in the machine. He does not like to participate in groups and it has only been with the support and encouragement of the staff that he is able to leave his room and interact at all with the other residents. He does visit with those residents sitting at his meal table and he will attend bingo. However, he will not participate in bingo, but instead watches and then talks to staff about what went on during the activity. Duvall does not like to go outside of the facility and insists on staff purchasing everything for him. He does go to town once each year for his physical examination.

The state mental health office has indicated that due to the nature of the OBRA legislation, they would be recommending that Duvall did not require active treatment and should be placed in an alternative setting.

Efforts have been made to select an alternative placement setting for Duvall. He was evaluated by staff from the group home for mentally ill individuals in Green River. They reported that he appeared unable to manage living in a more independent setting. They did not feel that their staff would be able to provide sufficient structure and supervision to provide for his feelings of safety. It was felt that placement outside of his protected setting could result in deterioration that could then lead to hospitalization.

While the nursing facility may not be the most ideal placement situation for Duvall, it has provided him with an opportunity to live in a less restrictive setting than the state hospital. His lack of independent living skills creates a major hurdle in placement efforts. Duvall's illness creates considerable fearfulness of the outside. He is unable to function without becoming agitated if he does not have sufficient structure and supervision to make him feel safe. The programs provided for him at the nursing facility offer him meaningful activity each day without pushing him into a stressful situation.

At this time, there is no facility in Wyoming that would be able to provide Duvall with the support necessary for him to maintain at his current functioning level. The nuturing type of support provided by the nursing facility staff has been instrumental in Duvall's progress. In a state with limited population, human resources are not always available unless agencies are willing to become flexible. In a state with a larger population base, there would be enough persons with Duvall's particular care needs to justify to creation of a separate treatment program. However, where his needs are for nuturing and support, this has best been provided by the nursing facility staff trained in provided similar care to the elderly.

Written Testimony Wyoming State Hospital August 2, 1990

Junior

Junior is a forty-two year old male who experienced his first WSH admission in 1966 at the age of eighteen. He remained in the hospital, with the exception of a couple of short term placement attempts, until 1988. At that time arrangements were made for his placement at a nursing facility.

While in the nursing facility, Junior is able to attend to his own activities of daily living with little encouragement from the staff. Prior to and during his hospitalization, Junior had experienced numerous violent episodes. In the nursing facility, he has been cooperative to taking his medications and has not experienced any violent episodes. He does continue to mumble to himself, probable in response to audio hallucinations. However, he tends to keep his diaglogue at a mumble.

Junior does not possess any independent living skills. He has been able to do some simple cooking tasks, however, all the planning and shopping was done by staff. In talking about possibly leaving the nursing facility, his voice became very soft and he quit talking before indicating any alternative to living in the nursing facility.

The state mental health office has indicated that due to the nature of the OBRA legislation, they would be recommending that Junior did not require active treatment and should be placed in an alternative setting.

Efforts have been made to select an alternative placement setting for Junior. He was evaluated by staff from the group home for mentally ill individuals in Green River. They reported that he appeared unable to manage living in a more independent setting. They did not feel that their staff would be able to provide sufficient structure and supervision to provide for his feelings of safety. Due to his lack of independent living skills, long term institutional living and lack of motivation, it was felt that Junior was not appropriate for thier facility. There was concern that placement outside of the nursing facility could result in deterioration that could then lead to hospitalization.

While the nursing facility may not be the most ideal placement situation for Junior, it has provided him with an opportunity to live in a less restrictive setting than the state hospital. His lack of independent living skills creates a major hurdle in placement efforts. The programs provided for him at the nursing facility offer him meaningful activity each day without pushing him into a stressful situation that he is not equiped to handle.

At this time, there is no facility in Wyoming that would be able to provide Junior with the support necessary for him to maintain at his current functioning level. The nuturing type of support provided by the nursing facility staff has been instrumental in Junior's progress. In a state with limited population, human resources are not always available unless agencies are willing to become flexible. In a state with a larger population base, there would be enough persons with Junior's particular care needs to justify to creation of a separate treatment program. However, where his needs are for nuturing and support, this has best been provided by the nursing facility staff trained in provided similar care to the elderly.

Item 8

Doctors doubt Medicare help coming from feds

c ST
8/26/9c

By WILL ROBINSON
Star-Tribune staff writer

CASPER — Medicare payments to Wyoming physicians lag behind payments in much of the country, and doctors here are skeptical that federal attempts to sort out the inequities will have any benefit.

A recently departed internist and three other Casper doctors have condemned the system, saying its ultimate effect is to deprive all Wyoming people of adequate health care. (See related story on A1.)

Congress last year made a pass at addressing Medicare reimbursement problems when, motivated by astronomical costs of the Medicare program, it overhauled the program's payment system.

Among the provisions in that legislation was the "resource-based relative value scale." In theory at least, the scale measured the time, training and skill required for a physician to perform a particular service, allowed for overhead costs and geographical differences, and adjusted Medicare payments accordingly.

The new scale is intended to keep the income gap between rural and urban doctors from growing. It would temper Medicare's tendency to reward doctors more for procedures like surgery and diagnostic tests, and less for "primary care" — where a doctor is engaged in a variety of duties, and spends much time talking with patients, rather than doing things to them.

DAVID DRIGGERS
Small towns need assistance

But the value scale is to be phased in over a five-year period, beginning in 1992, which meanwhile leaves rural doctors impatiently awaiting the reform — or heading for urban practices.

Most Wyoming doctors have made up the shortfall in Medicare reimbursements by charging patients more than the fees set by Medicare. Patients pay this amount out of their pocket.

But the federal legislation passed in 1989 will curtail the practice to some extent by gradually reducing the amount doctors can charge above and beyond Medicare fees.

The Rural Health Improvement Act now before Congress is intended to fine-tune the 1989 bill. Among other things, it would eliminate the five-year phase-in of the value scale and provide tax credits to rural primary care physicians. The measure is sponsored by Sen. Bob Packwood of Oregon and cosponsored by Wyoming Republicans Al Simpson and Malcolm Wallop, among others.

But Casper doctors Jim Haden and David Driggers expressed a general distrust that federal action would actually address the prob-

Continued

Doctors doubt Medicare help coming from feds

C ST
8/26/90

2/2

lem. Both said that although the federal government indeed seems intent on cutting reimbursements for urban specialists, the national budget crunch makes it unlikely that rural doctors are going to enjoy significant payment increases as the legislation is implemented.

"The result is rural areas are going to lose health care services, simply because we don't have enough voice in Congress," Haden said.

Driggers said that designation of the entire state of Wyoming as a "Health Manpower Shortage Area," where physicians receive what are essentially hardship area Medicare pay boosts — might be one solution. There are more than 1,000 such communities in the United States now — "14 or 15 in Wyoming," Driggers said.

However, Driggers said, "The criteria for developing the areas are difficult to apply to Wyoming, even though the whole state ought to qualify as a frontier state."

Those criteria include, in part: percentage of minorities; percentage of "special populations" such as homeless, migrant workers, elderly, people with AIDS, and substance abusers; percentage of population below the poverty level; and the infant mortality rate. None of these are particularly serious in

one solution. There are more than 1,000 such communities in the United States now — "14 or 15 in Wyoming," Driggers said.

However, Driggers said, "The criteria for developing the areas are difficult to apply to Wyoming, even though the whole state ought to qualify as a frontier state."

Those criteria include, in part: percentage of minorities; percentage of "special populations" such as homeless, migrant workers, elderly, people with AIDS, and substance abusers; percentage of population below the poverty level; and the infant mortality rate. None of these are particularly serious in

Wyoming, said Larry Meuli, administrator of the state Division of Health and Medical Services.

"We don't have the technical assistance in the state to help the small communities just to get through the bureaucracy (in order to be labeled a Health Manpower Shortage Area)," Driggers said. "The state needs to provide the technical assistance to these communities to find out whether they really qualify."

"This is a rural hospital problem, a rural health care delivery problem," Driggers said. Congress is well aware of the problem, he said, "but they pass legislation, and in the implementation of the legislation, something gets lost."

Item 9

YOUR EXPLANATION OF MEDICARE BENEFITS

READ THIS NOTICE CAREFULLY AND KEEP IT FOR YOUR RECORDS
THIS IS NOT A BILL

HEALTH CARE FINANCING ADMINISTRATION

May 15, 1990

VERDA BILLINGS
1820 29TH ST
CODY WY 82414

For more information call or write
MEDICARE PART B
4510 13TH AVENUE S.W.
FARGO, NORTH DAKOTA 58121-0001
PHONE AREA CODE 307-632-9381
CALL TOLL FREE 1-800-442-2371

Participating doctors and suppliers always accept assignment of Medicare claims. See back of this notice for an explanation of assignment. Write or call us for the name of a participating doctor or supplier or for a free list of participating doctors and suppliers.

Your doctor or supplier did not accept assignment of your claim totaling [redacted] (See Item 4 on back)

		BILLED	MEDICARE APPROVED
DR F H SCHMIDT SURGERY Amount approved limited by Item 5C on back.	APR 09-APR 09,1990	$ 1195.97	$ 827.10
DR F H SCHMIDT SURGERY Amount approved limited by Item 5C on back.	APR 09-APR 09,1990	$ 750.00	$ 413.55
DR F H SCHMIDT SURGERY Amount approved limited by Item 5C on back.	APR 09-APR 09,1990	$ 325.00	$ 273.45
Total approved amount			$ 1514.10
Medicare payment (80 % of the approved amount)			[redacted]

(You have met $ 75.00 of the $ 75.00 deductible for 1990)

IMPORTANT: If you do not agree with the amounts approved you may ask for a review. To do this you must write to us before Nov 15, 1990 (See item 1 on the back.)

DO YOU HAVE A QUESTION ABOUT THIS NOTICE? If you believe Medicare paid for a service you did not receive, or there is an error, contact us immediately. Always give us the:

Medicare Claim No. *520-16-8494A* Claim Control No. *539012040102000*

02068

YOUR EXPLANATION OF MEDICARE BENEFITS

READ THIS NOTICE CAREFULLY AND KEEP IT FOR YOUR RECORDS
THIS IS NOT A BILL

HEALTH CARE FINANCING ADMINISTRATION

May 15, 1990

VERDA BILLINGS
1820 29TH ST
CODY WY 82414

For more information call or write
MEDICARE PART B
4510 13TH AVENUE S.W.
FARGO, NORTH DAKOTA 58121-0001
PHONE AREA CODE 307-632-9381
CALL TOLL FREE 1-800-442-2371

REMARKS:

[redacted] are paying a total of $[redacted] to you on the enclosed check. Please cash it as soon as possible.

[redacted] Had your doctor accepted assignment, your bill would have been reduced $ 756.87, the difference between the Billed and Medicare Allowed amount.

IMPORTANT: If you do not agree with the amounts approved you may ask for a review. To do this you must write to us before Nov 15, 1990 (See item 1 on the back.)

DO YOU HAVE A QUESTION ABOUT THIS NOTICE? If you believe Medicare paid for a service you did not receive, or there is an error, contact us immediately. Always give us the:

Medicare Claim No. 520-16-8494A Claim Control No. 539012040102000

03069